GEORGIA CHILD FATALITY REVIEW PANEL

Annual Report
Calendar Year 2003

Edward Lukemire
Chairperson

Sonny Perdue
Governor

January 2005

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GEORGIA CHILD FATALITY REVIEW PANEL

MISSION

To serve Georgia's children by promoting more accurate identification and reporting of child fatalities, evaluating the prevalence and circumstances of both child abuse cases and child fatality investigations, and monitoring the implementation and impact of the statewide child abuse prevention plan in order to prevent and reduce incidents of child abuse and fatalities in the State.

Acknowledgements

The Georgia Child Fatality Review Panel wishes to acknowledge those whose enormous commitment, dedication and unwavering support to child fatality review have made this report possible. These include:

- All the members who serve on each of the county child fatality review and child abuse protocol committes
- John T. Carter, Ph.D., and associates of the Epidemiology Department of Emory University, Rollins School of Public Health
- Mike Lavoie, Director of the Office of Vital Statistics
- Emily Kahn, PHD, MPH, Nicole Tucker, MPH, Maternal and Child Health Epidemiology Section, Epidemiology Branch, Georgia Division of Public Health
- All the other public/private agencies that have so willingly collaborated with this office and provided support

GEORGIA CHILD FATALITY REVIEW PANEL

MEMBERS

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Superior Court, Houston Judicial Circuit

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Mr. Bruce Cook
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Carri Cottengim
Program Manager

The Georgia Child Fatality Review Panel is an appointed body of 17 representatives that oversees the county child fatality review process, reports to the governor annually on the incidence of child deaths, and recommends prevention measures based on the data. Two year appointments are made by the governor except as otherwise noted.

1 Appointed by the Lieutenant Governor
2 Appointed by the Speaker of the House of Representatives
3 Ex-Officio

"Branching out for Prevention"

Georgia Child Fatality Review Panel

Dear Governor and Members of the Georgia General Assembly:

From its inception in 1990, the Georgia Child Fatality Review Panel has overseen a steady improvement in efforts to realize that portion of its mission involving identification, reporting and investigation of child fatalities. The year 2004 has witnessed a continuation of that trend. Because of the support and guidance - both financial and otherwise - which you have provided, the Panel has been able to accomplish the following in 2004:

- Achieve a ninety-five percent compliance rate by county committees for reviewing 2003 child deaths eligible for review. This is the highest compliance rate in Georgia Child Fatality Review history (88% for 2002 deaths, 75% for 2001, and 67% for 2000);
- Lobby for, and support the passage of, the Child Protection Bill (SB467) making recklessly and negligently placing a child in danger of harm a felony. This bill also makes it a felony to manufacture methamphetamine in the presence of a child;
- Institute an online coroner/medical examiner reporting system to assist in filing the Coroner's Report electronically;
- Implement a policy adding a Prevention Advocate to each county's Child Fatality Review Committee, and provide statewide training for designated Prevention Advocates;
- Collaborate with National Center for Child Death Review on creating a National Child Death Review Reporting Tool;
- Develop five additional Child Fatality Investigation Teams. This multi-disciplinary approach was created because highly specialized skills are required to properly investigate child deaths.

Sadly, as the identification and reporting aspects of our mission improve, they reveal with increasing clarity an environment which remains deadly for Georgia's most precious resources. For instance, in 2003 there are 161 child fatalities from confirmed or suspected abuse and/or neglect (up from 110 in 2002). Intentional child deaths (homicides and suicides) increased from eighty-three in 2002 to ninety-nine in 2003. Child deaths from motor vehicle incidents increased from 192 in 2002 to 211 in 2003. These and other statistics, obtained from local child fatality review committees, testify to the urgent need for our communities to become increasingly proactive in their approach to the problem; i.e. there must be more emphasis on prevention efforts. The Panel remains committed to developing, implementing and promoting such efforts.

We live in an increasingly violent and dangerous world, and the most innocent among us are disproportionately victimized in this environment. However, conceding this fact in no way concedes the battle; it only serves to motivate this Panel to redouble our efforts and do what it takes- for as long as it takes- to reduce child fatalities in Georgia. You have been an integral part of this struggle; we are grateful to you for that, and we solicit your continued involvement and support.

Edward D. Lukemire, Chairperson
Judge of Superior Court, Houston Judicial Circuit
Georgia Child Fatality Review Panel

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Each year, the staff of the Georgia Child Fatality Review Panel (Panel) assesses both the progress of child fatality review (cfr) in each of the 159 local counties, and the influence of cfr at the State level. This information assists us in determining the impact of our current efforts, and charting our course for the future. When examining the work of local cfr committees, four key elements are measured: member participation, percentage of eligible deaths reviewed, thoroughness/accuracy of reports, and advocacy for prevention. Annually, we have seen improvement in each of these areas:

1) There are eight disciplines mandated by law or policy to have member participation on cfr committees. The 586 child fatalities reviewed in 2003 had approximately 75% of all members present at each review
2) The percent of eligible deaths reviewed continues to increase, with no exception for 2003. Counties reviewed 556 of 586 eligible deaths representing a 95% compliance rate
3) The number of reports received requiring additional or amended information decreased, indicating counties have a better understanding of information needed, and are more diligent in obtaining it
4) An increase in the number of counties making, and advocating for prevention recommendations within their counties and to the State, demonstrates a fundamental shift in thinking regarding the purpose and potential of cfr

When evaluating cfr influence at the State level, our focus has been primarily in three (3) areas: regulatory recommendations, legislative recommendations, and education. A number of regulatory and legislative recommendations were made in the Panel's Annual Report for 2002 child deaths.

The results of those acted upon included:

DFCS
- Initial efforts to strengthen the child protective services risk assessment and safety tools

Coroners
- An increase in the number of death scene investigations conducted for suspicious, unexpected, and unexplained child deaths

Legislation
- The Child Protection Bill, which was supported by the Panel
- A broader child restraint law for children under the age of 7, which was supported by the Panel

Education
- Extensive efforts by Panel staff to educate human service professionals, government officials, legislators, law enforcement, and child advocates on both the prevalence of child deaths, and opportunities for prevention. Various channels of communication were employed

Our assessment of this past year revealed that progress has been made at both the county and state levels. This systematic progress positions us to proceed to the next step – a statewide, injury prevention plan. A plan for children neglected and abused; a plan for children dying from injuries sustained unintentionally; a plan for children whose lives are lost at the hands of another; a plan for children whose lives seem so miserable that death is a welcomed relief.

One lesson learned is that collaboration and teamwork at local and state levels are necessities if success is to be realized. Therefore, this plan must be crafted by all of us whose mission is the safety and protection of children. We must see our work in promoting the well being of children as a continuum of care, and not operate with tunnel vision. It really does take a village to raise a child.

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EXECUTIVE SUMMARY

The Georgia Child Fatality Review Panel (Panel) publishes an annual report chronicling the tragic, preventable deaths of children in Georgia. Information in this report details deaths that were sudden, unexplained and/or unexpected. This information is compiled from reports submitted by local child fatality review committees. The Panel is charged with tracking the numbers and causes of child deaths as well as identifying and recommending prevention strategies that could reduce the number of child deaths.

Key Findings

In 2003, 1,794 children died in Georgia. Based on death certificate data, 586 deaths were eligible for review. Child fatality review committees reviewed 556 (95%) of those deaths and an additional 119 deaths; however, the cause of death listed on death certificates and the cause of death determined by child fatality review committees sometimes differed.

FATAL CHILD ABUSE/NEGLECT

Department of Family and Children Services reported that 70 children in Georgia died as a result of substantiated abuse or neglect. Those deaths were investigated by DFCS, and did not include deaths handled by law enforcement and the courts without DFCS involvement.

Child fatality review committees determined that 82 child deaths resulted from confirmed abuse/neglect, and 79 child deaths resulted from suspected abuse/neglect. Perpetrators were identified in 118 of the 161 abuse/neglect related deaths, as well as the relationship of the perpetrator to the child. Fifty-two percent (52%) of those perpetrators were natural parents. Homicide was the cause of 42 confirmed abuse deaths, and children under the age of 5 accounted for 79% (33) of those homicides.

NATURAL

Death certificate data indicated a total of 1326 children under the age of 18 died of natural causes (including SIDS). Infants accounted for the vast majority (1,074) of those deaths. The leading causes of infant deaths continued to be congenital anomalies, low birth weight, and prematurity. There were 103 SIDS deaths, which was a 27% decrease from the previous year.

Child fatality review committees reviewed 234 deaths from natural causes. One hundred twenty-one (121) of those deaths were SIDS/SUID. (SUID – Sudden Unexplained Infant Death - is a term used for a death that appears to be SIDS, but has other factors that *could* have contributed to the death.) Committees are required to review all SIDS/SUID deaths, and medical deaths that are unexpected or unattended by a physician.

INJURIES

Death certificate data listed 441 deaths to have resulted from known injuries, but 6 of those deaths listed an unknown intent. An additional 27 deaths listed an unknown cause.

UNINTENTIONAL INJURIES

Death certificate data indicated that 59% (383) of deaths in children ages 1 – 17 resulted from injuries (infant deaths [1150], were mostly due to natural causes [1074]). Seventy-seven percent (77%) of all injuries in the 1 – 17 year age group resulting in death were unintentional (excludes unknown intent and unknown cause). The 3 leading causes of unintentional injury-related deaths in all age groups were:

- 211 motor vehicle incidents
- 37 drowning incidents
- 25 fire/burn related incidents

There was a slight increase in the number of all deaths caused by unintentional injuries (from 324 to 336) over the previous year. The most marked increase in unintentional deaths from 2002 was suffocation (19 in 2002 to 35 in 2003).

Child fatality review committees reviewed 334 deaths attributed to unintentional injuries. Child fatality review and death certificate data agreed on the 3 leading causes of death related to unintentional injuries (see above). Committees also identified a marked increase in the number of deaths due to suffocation (21 in 2002 to 40 in 2003).

INTENTIONAL INJURIES

Death certificate data indicated 99 children died from injuries intentionally inflicted by themselves or by others (homicides and suicides). In 2003, there were 71 homicides (a 22% increase from 2002), and 28 suicides (a 12% increase).

Child fatality review committees reviewed 101 deaths from intentional causes – 71 homicides and 30 suicides. Committees determined additional deaths to have resulted from suicide that were not identified as such on death certificates.

FIREARM DEATHS

Death certificate data indicated firearms were used in 43 child deaths. Thirty-two (32) of those deaths were ruled homicides, and 11 were ruled suicides.

Child fatality review committees reviewed 43 firearm related deaths. Eighty-six percent (86%) were intentional (26 homicides and 11 suicides). The type of firearm was identified in 39 of the 43 reviewed firearm related deaths. Handguns were most frequently used (31 of the 39 deaths where type of firearm was identified).

UNKNOWN DEATHS

Death certificate data identified 27 infant/child deaths with an "Unknown" cause of death. CFR committees reviewed 24 of those 27 deaths and assigned an "Unknown" cause to only one of the 24. They determined the 23 deaths to be SIDS (3), SUID (9), medical cause (5), and 6 were other violent causes.

Child fatality review committees identified 4 deaths for which they were unable to determine a cause of death One of those deaths (referenced in preceding paragraph) also had "Unknown" ICD10 code on the death certificate. The death certificate assigned causes for the remaining 3 deaths as medical, SIDS, and poison.

PREVENTABILITY

A primary function of the child fatality review process is to identify those deaths believed to be preventable. The issue of preventability was addressed in all 675 child deaths reviewed. Child fatality review committees determined that 79% (533) of the 675 reviewed child deaths were definitely or possibly preventable. Ninety-six percent (96%) of all reviewed child abuse/neglect related deaths were determined to be definitely or possibly preventable.

AGENCY INVOLVEMENT/INTERVENTION

Child fatality review committees reported that in 108 (67%) of the 161child abuse/neglect related deaths, the child and/or family had prior involvement with at least one state or local agency. Committees identified 8 deaths for which they concluded an agency intervention could have prevented the death. Four (4) of those 8 deaths had an abuse/neglect finding.

ACCOMPLISHMENTS, RECOMMENDATIONS, AND GOALS OF THE GEORGIA CHILD FATALITY REVIEW PANEL

Accomplishments:

1. Achieved a 95% compliance rate for county committees reviewing 2003 child deaths eligible for review. This is the highest compliance rate in Georgia Child Fatality Review history (88% for 2002 deaths, 75% for 2001 and 67% for 2000)
2. Advocated for, and supported the passing of the Child Protection Bill (SB467) making recklessly and negligently placing a child in danger of harm a felony
3. Published and distributed a Statewide Model Child Abuse Protocol Manual to all county protocol committee members, which was developed through a partnership with the Office of the Child Advocate, the Department of Family and Children Services (DFCS), and the Georgia Bureau of Investigation (GBI)
4. Instituted an online coroner/medical examiner reporting system to assist in filing the Coroner/Medical Examiner's Report electronically
5. Implemented a policy adding a Prevention Advocate to each county's child fatality review committee. Provided statewide training for designated prevention advocates
6. Collaborated with the National Center for Child Death Review on creating a "National Child Death Review Reporting Tool"
7. Created five (5) additional child fatality investigation teams. Because of the highly specialized skills required to thoroughly investigate child deaths, a multi-disciplinary approach was created and has continued to be implemented statewide
8. Co-sponsored an annual conference with DFCS, Office of Child Advocate, and GBI on serious injury and child fatality

Legislative Recommendations:

1. Fully implement recommendations of the Child Protective Service Task Force to improve the state's ability to protect children from child abuse and neglect
2. Fund expansion of home-based family support models that promote and enable appropriate parenting skills for prevention of child abuse and neglect
3. Require fences and gates in public and private swimming pools statewide
4. Require an autopsy, including toxicology studies, for every death of a child under the age of seven with the exception of children who are known to have died of a disease process while attended by a physician. Further, require complete skeletal x-ray (following established pediatric and radiological protocol), of the bodies of children who died before their second birthday
5. Provide sufficient funding to the Georgia Child Fatality Review Panel to fulfill statutory requirements
6. Expand funding for mental health services for children, especially those identified as "at risk"
7. Continue efforts to improve child restraint law to include children under the age 9

Agency Recommendations:

1. DFCS: The Panel recommends that when a child dies due to parent(s) or caretaker(s) neglect or aggression, efforts be made to visit the surviving children in the home on an on-going basis to assess their safety and well-being, and enable referrals to appropriate services
2. DFCS: Further strengthening of the risk assessment and safety tools to more accurately assess risk to children
3. Public Health: Expand efforts of the public awareness campaign regarding safe sleeping environments to include risk factors associated with co-sleeping
4. Coroner and Medical Examiner's Offices: The Panel recommends that a death scene investigation be conducted for any child death that is suspicious, unexpected, autopsy, and/or unexplained. No case should be classified as SIDS unless a death scene investigation, and review of the clinical circumstances are completed

Goals:

1. Collaborate with relevant organizations to develop a statewide child abuse/child injury prevention plan
2. Increase child fatality review committees reporting compliance to 97%
3. Develop five (5) additional child fatality investigation teams in the state

GEORGIA CHILD FATALITY INVESTIGATION PROGRAM

Child deaths are inherently difficult to investigate due to the unique nature of medical findings and fact patterns in the vast majority of cases. The growing national trend is to utilize a multi-disciplinary team approach from the inception of such investigations to maximize the information-gathering and decision-making capabilities of authorities. Child death investigation teams recognize the value of employing the particular expertise and resources each involved agency brings to the investigation. These teams utilize highly trained representatives from their own district attorney's offices, local law enforcement agencies, coroners and/or medical examiners, and the Department of Family and Children Services. Regional specialists from the Georgia Bureau of Investigation are available to assist teams as well.

The Georgia Child Fatality Investigation Program was created to develop and support multi-disciplinary child death investigation teams in communities around the state. The program is the result of collaboration between the Georgia Child Fatality Review Panel, the Georgia Bureau of Investigation and the Department of Family and Children Services. In 2004, Rachelle Carnesale, a former child abuse prosecutor, became the Director of the program.

Numerous jurisdictions around Georgia have agreed to participate in the Georgia Child Fatality Investigation Program and are receiving assistance and training upon request and without any cost. Model protocols are available as well as initial and follow-up trainings and case consultations. Resource notebooks designed for teams to utilize at death scenes are offered to participating teams as well. For 2005, teams will receive quarterly newsletters with information about upcoming national conferences, emerging medical trends, approaches to common defenses and other helpful information. In 2004, participating teams were offered a networking opportunity with one another in Macon. The program looks forward to offering networking opportunities such as roundtable discussions and special group trainings in 2005.

The original jurisdictions involved in the pilot program include: Lookout Mountain Judicial Circuit, Middle Judicial Circuit, Douglas Judicial Circuit, Dougherty Judicial Circuit, Stone Mountain Judicial Circuit, Eastern Judicial Circuit, Rome Judicial Circuit, Northeastern Judicial Circuit, Alcovy Judicial Circuit, Southern Judicial Circuit, and Tifton Judicial Circuit.

The following jurisdictions enrolled in the program in 2004: Blue Ridge Judicial Circuit, Bell-Forsyth Judicial Circuit, Clarke Judicial Circuit, Rockdale Judicial Circuit, and Gwinnett Judicial Circuit.

In 2003, 586 cases of child death were considered eligible for review by Child Fatality Review teams around the state. Law enforcement attended the scene in 503 deaths, while corners or medical examiners responded to the scene in only 301 deaths. A number of scenes were attended by EMS, fire investigators, or other agencies as appropriate.There were 16 deaths in which an investigation did not occur.

INFORMATION SOURCES AND INCONSISTENCIES

This annual report on Georgia's 2003 infant and child fatalities uses two related but independent sources of data - death certificate (dc) data collected by the Vital Statistics Unit and prepared by the Office of Health Information and Policy (OHIP), and the child fatality review data collected by the Office of Child Fatality Review. These two data sources do not always agree on the cause or manner of death. Child fatality review reports are the primary source of data for this report.

The dc data provides a count, and the provided ICD10 coding (International Classification of Diseases) for cause, of all infant and child deaths, and is used to identify the set of "reviewable" deaths. For child fatality review purposes, the relevant ICD10 codes include deaths due to unknown or undetermined cause, SIDS, and any death due to accident or violence. A medical examiner, coroner, or cfr team may also determine that a death should be reviewed because of the circumstances of the death (e.g., the child was not under the care of a physician). Thus, the total number of reviewed deaths in a county may exceed the number of deaths identified as "reviewable" based on the death certificate.

Child fatality review reports provide details of the cause, manner and circumstance of death, supervision at time of death, prior history of abuse or neglect, others identified as causing or contributing to child deaths, and prior agency involvement. Reports also contain information regarding whether a death might have been prevented and what measures might be taken to lessen the likelihood of a similar death occurring in the future.

Though death certificate and child fatality review data do not always agree, the causes of death are consistent between the two sources for a majority of deaths. The team may have had access to additional information and may come to a different conclusion regarding the cause and/or manner of death. The system used in the coding of the causes of death on the death certificate, the ordering of reported codes to select the underlying cause, and the collapse of codes into categories all contribute to error in the classification of the death certificate "cause" of death. One of the values of the cfr process is that it provides a check on the death certificate coding of cause.

The process of linking the death certificates and child fatality review reports is not perfect. In 2003, there were 15 child fatality review reports with no identified matching death certificate. (Those deaths would only be included in the "Total Reviews" data in Appendix E.) There were 75 reviews that had a different cause of death than was determined from the ICD10 coding for cause of death on the death certificate. Though some adjustments have been made to the cause of death or county of residence in the death certificate data based on information gathered in reviews, there are additional identified differences that have not been reconciled. In some cases there was apparent miscoding of the cause of death on the death certificate, and those deaths have been identified to Vital Statistics. However, as previously stated, the "reviewable deaths" have been defined based on the provided ICD10 codes.

CHILD DEATHS IN GEORGIA

In 2003, 1,794 children died in Georgia, which was equivalent to almost 5 deaths per day. Most of those deaths were due to medical causes (1,208), and occurred among infants (956). Of the 1,794 child death certificates filed in 2003, 586 met the criteria requiring review. Child fatality review committees reviewed 556 (95%) of those eligible deaths. Motor vehicle-related deaths continue to be the overall leading cause of injury-related death for Georgia's children. Though SIDS includes only infants, it is the second leading cause of death for all children under age 18, when medical deaths are excluded.

SUMMARY OF ALL DEATH

Figure 1. Deaths to Children Under Age 18 in Georgia, All Causes Based on Death Certificates, 2003

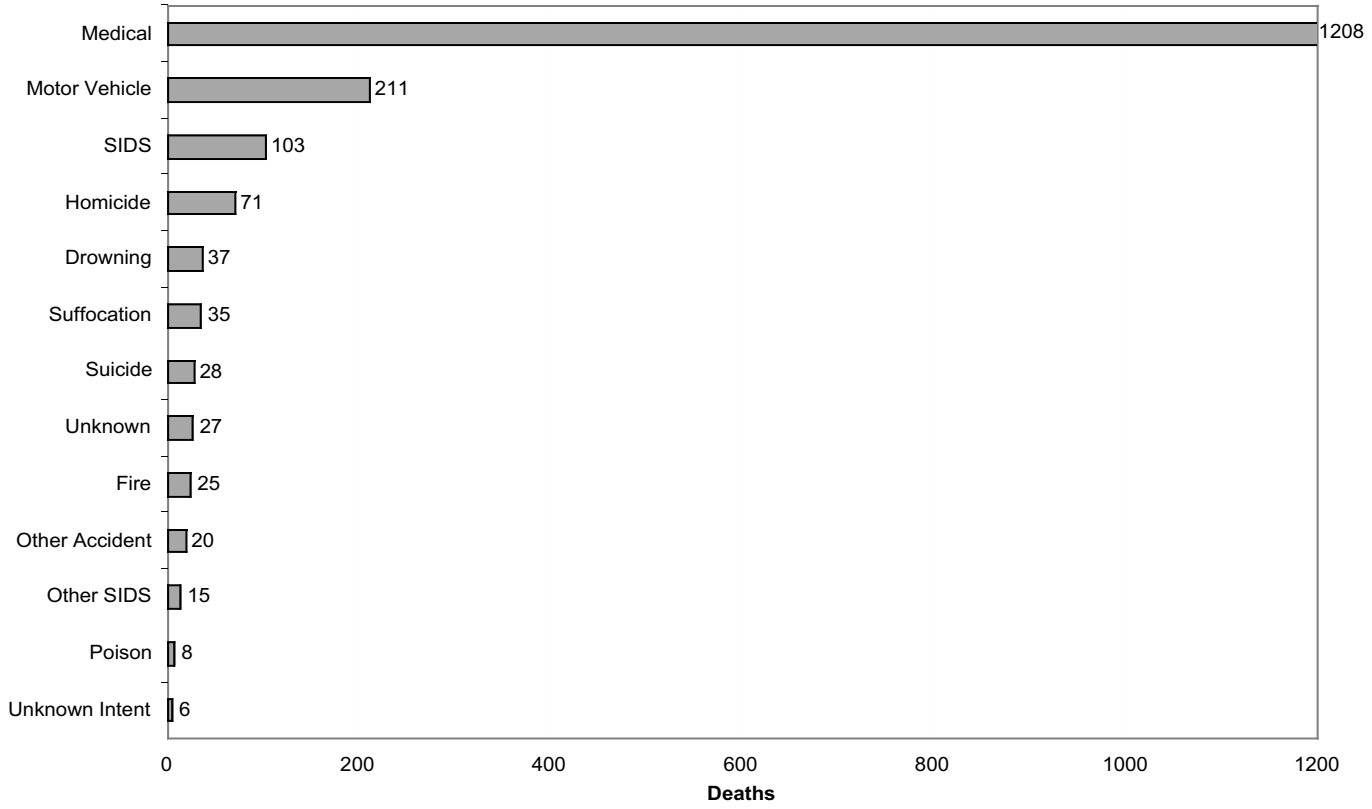


Figure 1 shows the causes of all 1,794 child deaths in Georgia in 2003. Natural causes were responsible for 74% (1,326) of all deaths, with 81% (1,074) of those deaths occurring before age 1

The term "medical" when used in this report as a cause of death for infants does not include SIDS

Findings

- The total number of infant/child deaths (1,794) is higher than the average number of deaths per year (1,743) for the period 1997-2002
- In 2003 motor vehicle-related deaths represented the largest increase (from 192 in 2002 to 211 in 2003). The largest decrease was associated with SIDS related deaths (from 141 in 2002 to 103 in 2003)

Findings

- African American children make up 34% of the child population; however, their deaths make up 48% of all child deaths
- Although not shown in the figure, there is a slight decrease in deaths among Hispanic children (from 133 in 2002 to 126 in 2003)

Figure 2. Race and Gender of All Child Deaths, 2003

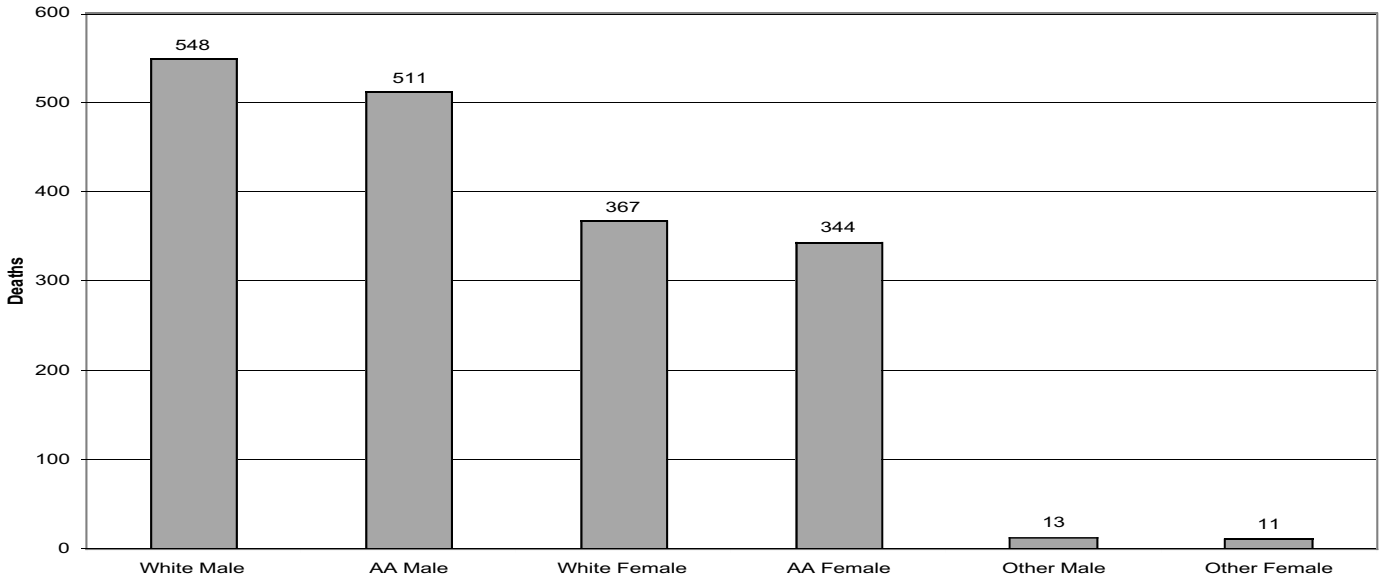
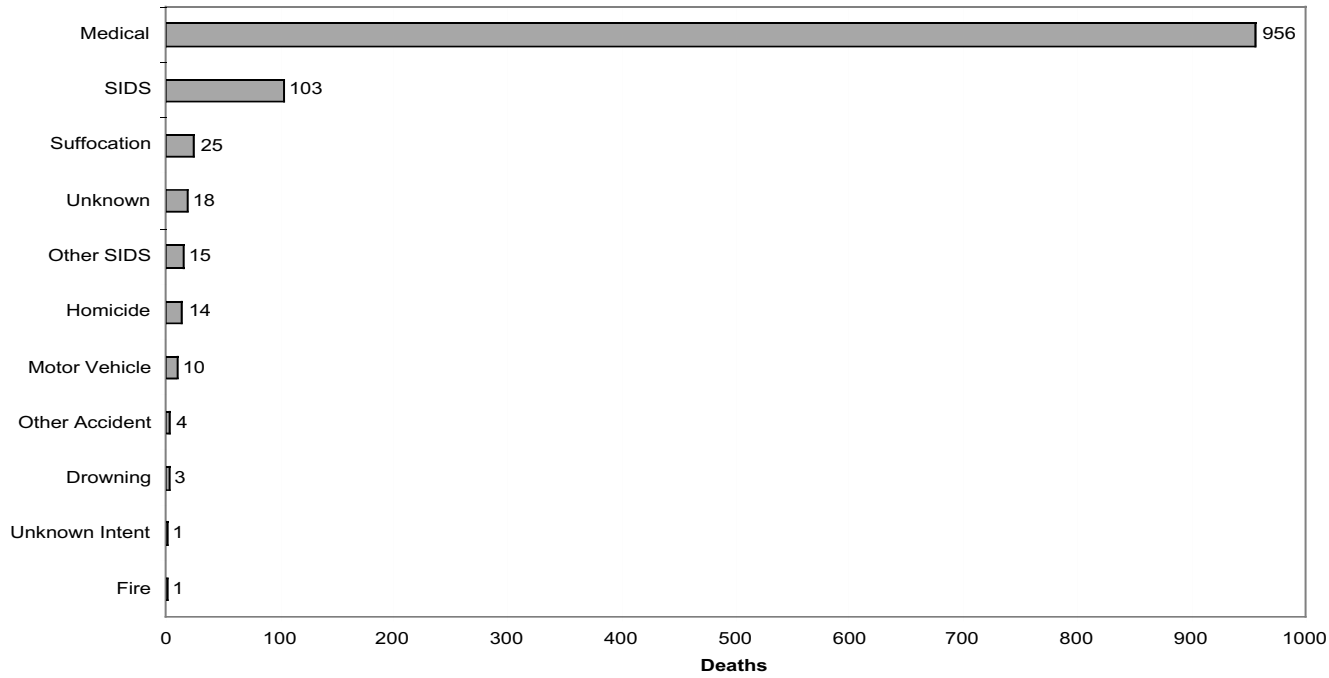


Figure 3. Causes of Death, All Infant Deaths, Georgia, 2003



Findings

- Only 58 infant deaths (5%) resulted from unintentional or intentional injuries. This was an increase from 2002 (44) but lower than 2001 (62)
- SIDS deaths decreased (from 141 in 2002 to 103 in 2003)
- Of defined causes, suffocation continued to be the largest single injury-related category

Findings

- Deaths in this age group continued to decrease (from 203 in 2001 to 179 in 2002 to 160 in 2003)
- Suffocation deaths increased (from 2 in 2002 to 8 in 2003)
- Both drowning and motor vehicle-related deaths decreased from 26 deaths each in 2002
- Homicide deaths increased (from 15 in 2002 to 19 in 2003)

Figure 4. Causes of Death, Children Ages 1 to 4, Georgia, 2003

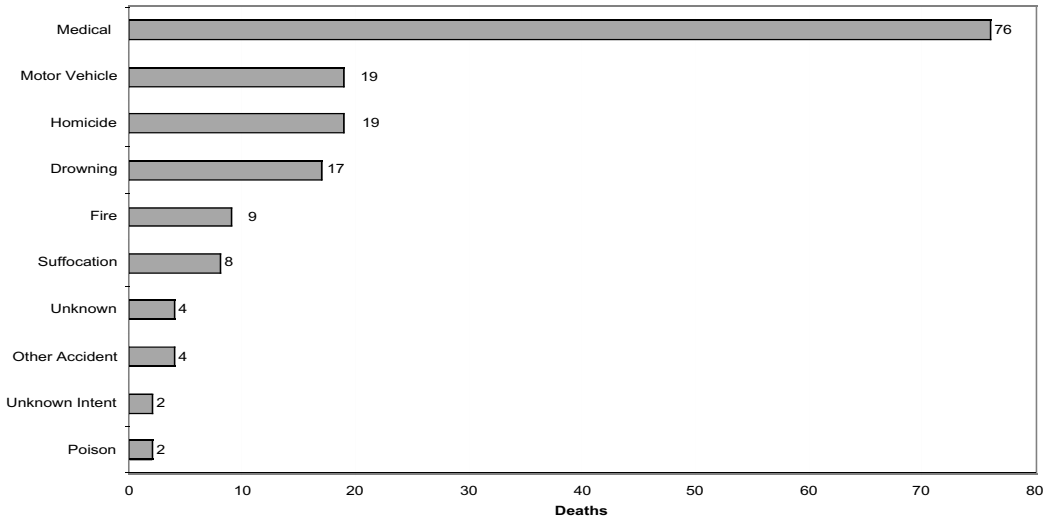
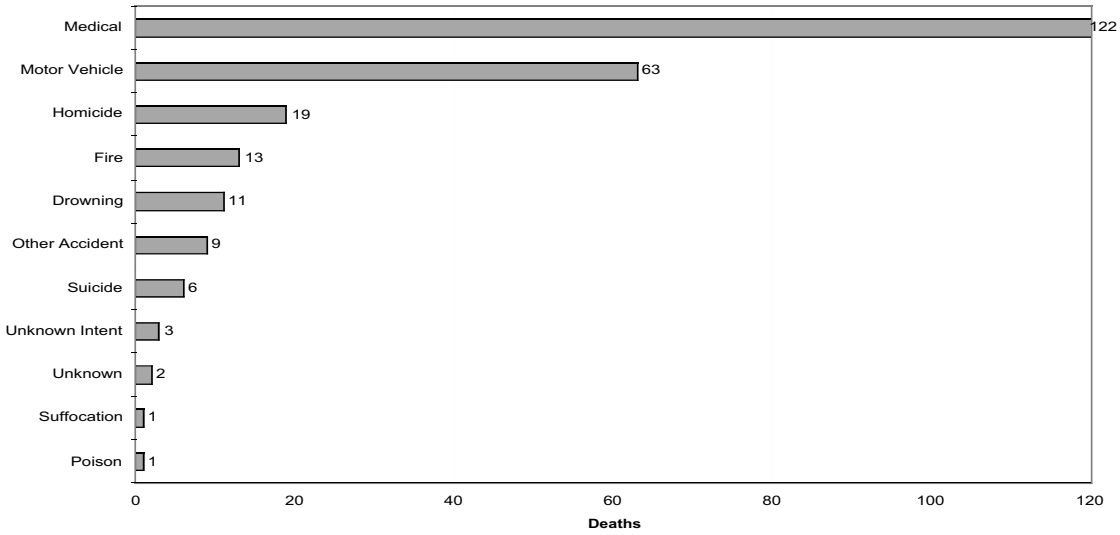


Figure 5. Causes of Death, Children Ages 5 to 14, Georgia, 2003



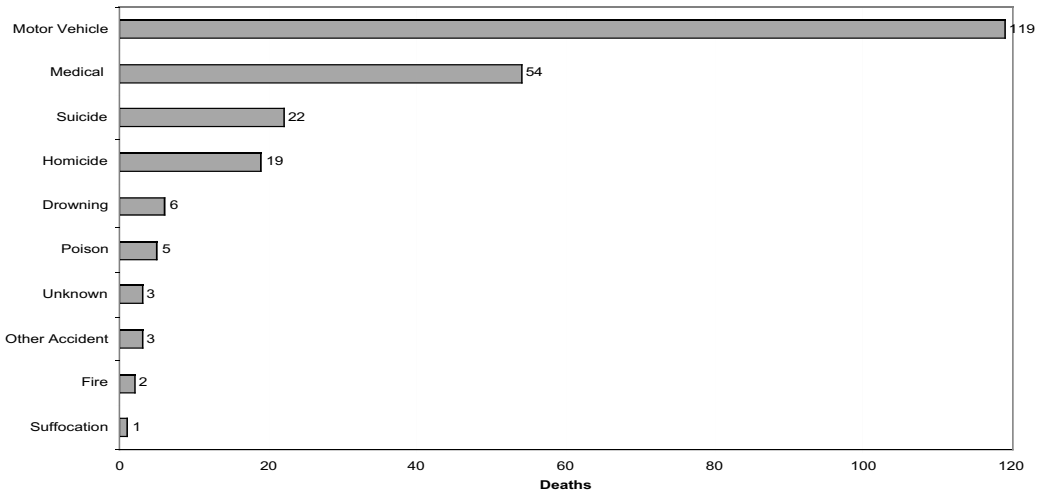
Findings

- 50% of deaths in this age group were caused by injuries
- 50% of those injuries were motor vehicle-related, representing a decrease from 2002 (55%)
- Total deaths (250) was an increase from 227 in 2002

Findings

- Deaths from homicides (19) represented the largest decrease in this age group (from 29 in 2002)
- 76% of all deaths in this age group were due to unintentional and intentional injuries
- 67% of injury-related deaths were due to motor vehicle-related incidents

Figure 6. Causes of Death, Children Ages 15 to 17, Georgia, 2003



ALL 2003 REVIEWED DEATHS

The purpose of the child fatality review process is to analyze all circumstances of child deaths. This process is critical in identifying prevention strategies that can help reduce needless deaths and improve the well-being of Georgia's future generations.

In 2003, 586 of the total 1,794 child deaths met the criteria requiring review (injuries and SIDS) according to death certificate data. (Medical deaths are indicated for review only if unexpected, unexplained, or unattended by a physician.) Committees filed reports for 95% (556) of eligible deaths within the reporting period, representing an increase of 8% since 2002. (This increase is attributed to extensive training and consultation provided to the counties, and the counties' commitment to the children of their communities.) Committees reviewed an additional 119 child deaths for a total of 675 deaths reviewed, and are included in Appendix C.2 of this report.

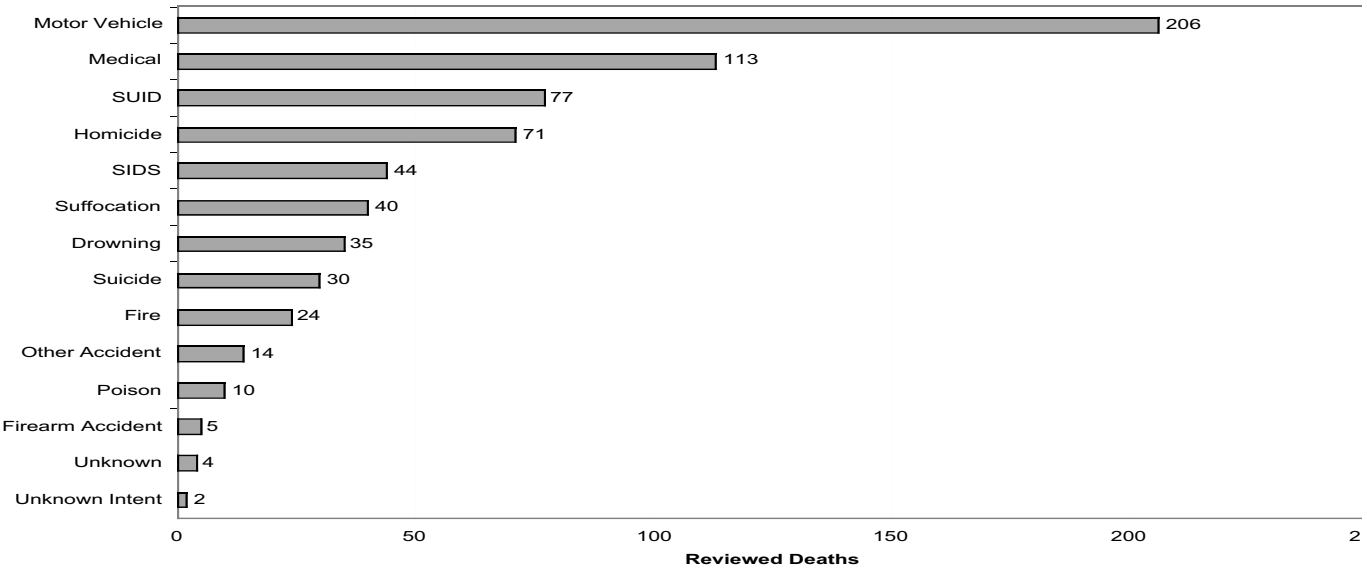
Except as noted, information and figures for this report are designated by the term "Reviewed Deaths". Those include all child deaths reviewed by committees (675) with the exception of deaths determined by committees to be medical (113), unknown (4), unknown intent (1) for a total of 562. All information presented in the "Trends" sections is based on death certificate data.

The distribution of child deaths in Georgia is generally proportional to the county population.

- The 14 counties with 10 or more reviewable deaths in 2003 have 51% of the child population and 46% (267) of all reviewable deaths. Those counties reviewed 98% (262) of their 267 reviewable deaths
- The 104 counties with 1 to 9 reviewable deaths reviewed 293 of their 310 reviewable deaths (95%). Only 5 counties with reviewable deaths did not review any of their reviewable deaths, and three of those counties had only 1 reviewable death
- Nine counties had no child fatalities in 2003, and an additional 31 counties had no child deaths that met the criteria for review

Five hundred fifty-six (556) deaths, (injuries and SIDS) are discussed in the "Reviewed Deaths" sections of this report. Reviews of medical deaths are not included unless noted.

Figure 7. Causes of Death, All Reviewed Infant/Child Deaths, Georgia, 2003



Findings

- Motor vehicle-related incidents continued as the leading cause of death among children
- For 2003 SIDS/SUID deaths, committees identified a larger percentage (64%) to be related to SUID than in the previous year (45%)
- For SIDS/SUID deaths, SIDS related deaths saw the greatest change with a decrease of 48%. SUID related deaths increased by 13%

PREVENTABILITY

A preventable death is defined by Georgia Child Fatality Review as one in which with *retrospective analysis,* it is determined that a *reasonable intervention* (e.g., medical, educational, social, psychological, legal or technological) could have prevented the death. It is critical that committees advocate for the implementation of recommendations made to prevent child deaths.

Each child fatality review report asks the committee to determine whether the child's death could have been prevented. All 675 reviews submitted in 2003 included this information.

Definitely Preventable	**39%**	**263**
Possibly Preventable	**40%**	**271**
Not Preventable	**21%**	**141**

The CFR Committees determination of preventability depended on the cause of death (see Appendix C).
- Fifty-six percent (56%) of unintentional injury-related deaths were determined to be definitely preventable
- Fifty-eight percent (58%) of intentional injury-related deaths were determined to be definitely preventable
- Sixty-eight percent (68%) of deaths related to abuse/neglect were determined to be definitely preventable

CHILD ABUSE AND NEGLECT

Each day in the United States, more than 3 children die as a result of child abuse in the home.

Research studies of infant child death data estimate that the actual rate of infant deaths attributed to substantiated abuse or neglect of infants and children up to 4 years of age is more than twice as high as the official rates reported in death certificate data. The actual incidence of abuse and neglect is estimated to be three times greater than the number reported to authorities. Nine in ten Americans polled regard child abuse as a serious problem, yet only 1 in 3 reported abuse when confronted with an actual situation (Child Help USA).

One hundred-sixty one (161) reviewed child deaths were determined by child fatality review committees to have been suspected (79) or confirmed (82) child abuse and/or neglect. (Data on the cause of death, age, race, and gender for those deaths are included in Appendix C.3 of this report.) When known, more than one-fourth (22) of reviewed injury deaths with abuse/neglect findings reported the injury as alcohol/drug related.

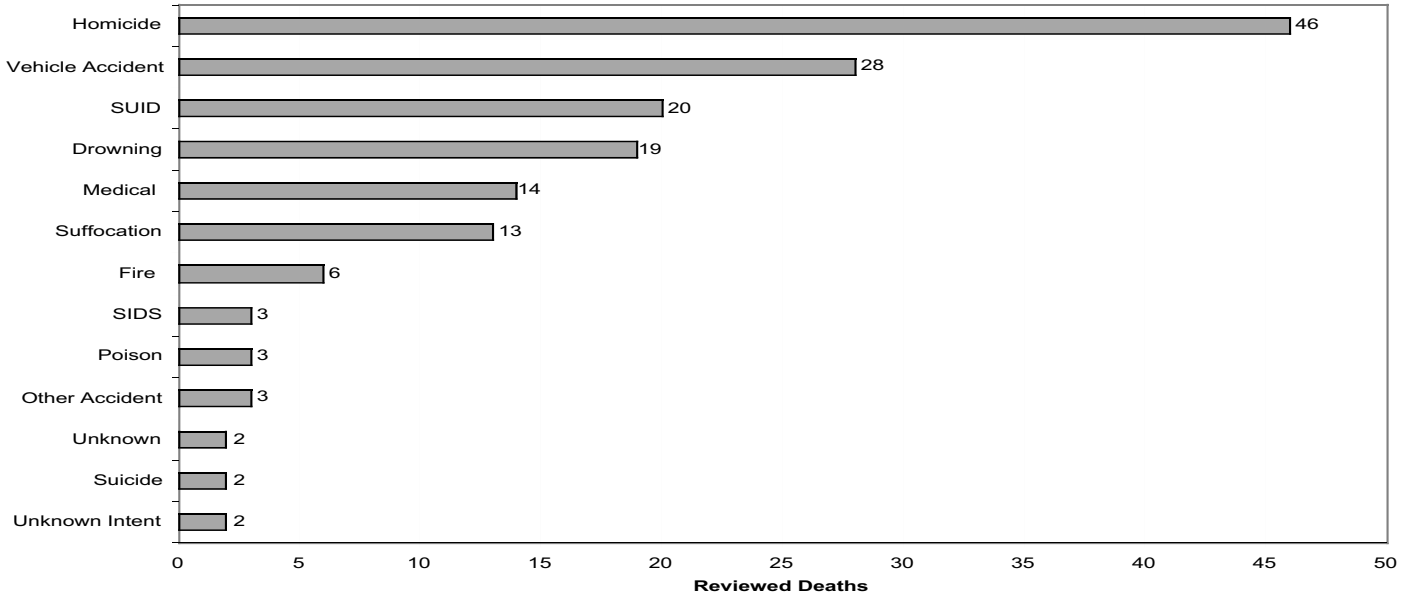
Domestic Violence and Child Abuse

Domestic violence is widespread and occurs among all socioeconomic groups. It is estimated that between 53% and 70% of batterers of partners also frequently abuse their children (Child Welfare Partnership). Other research suggests that women who have been hit by their husbands were twice as likely as other women to abuse a child. Children from homes where domestic violence occurs are physically or sexually abused and/or seriously neglected at a rate 15 times the national average (Child Welfare League of America).

A history of domestic violence in the home of the decedent was also associated with a committee finding of child abuse. For those decedents with prior abuse/neglect findings (suspected or confirmed), 32% of those with information available (29) had a history of domestic violence. Only 4 of the decedents with no abuse/neglect findings had a history of domestic violence.

A 4-month-old infant was shaken to death by her father because she threw up on his shirt. The father was arrested for domestic violence approximately two months prior to this incident and was bailed out by the mother of the infant.

Figure 8. Causes of Death, Reviewed Deaths with Abuse/Neglect Findings, Georgia, 2003

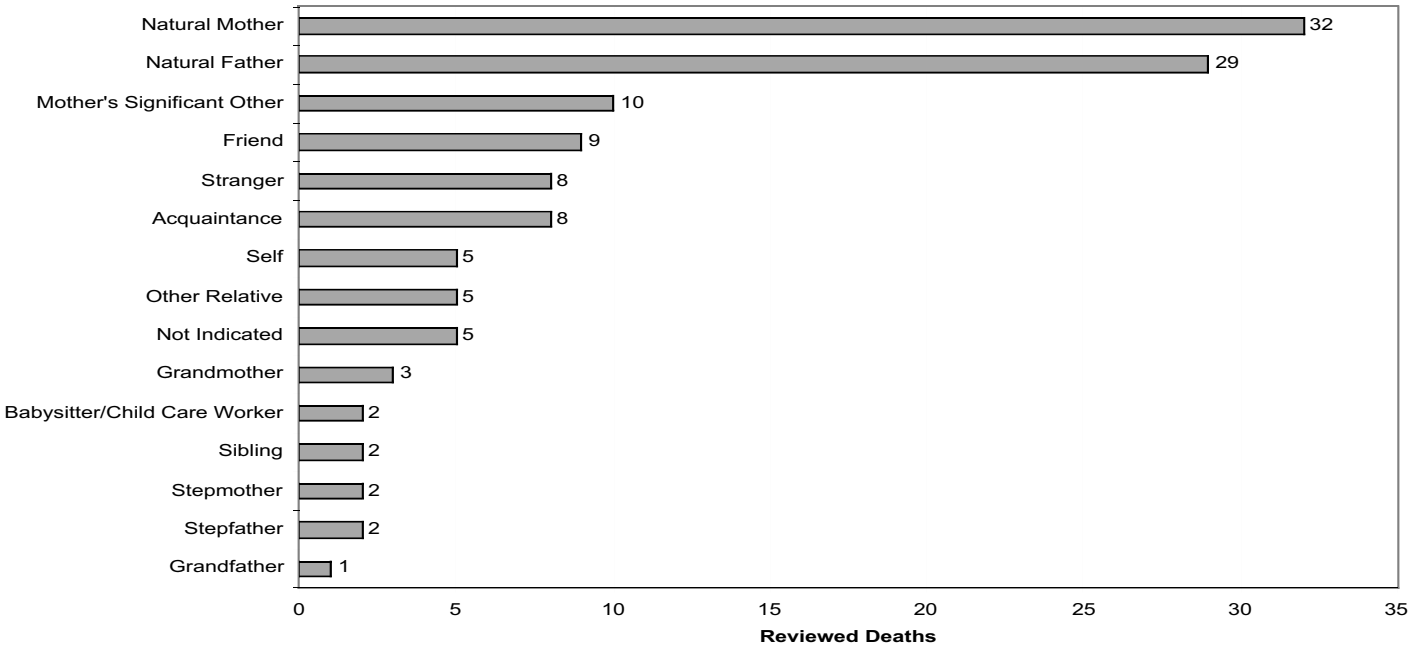


Findings

- 29% of reviewed deaths with child abuse or neglect findings were homicides
- Total number of deaths with abuse or neglect findings increased (from 110 in 2002 to 161 in 2003)

Perpetrators

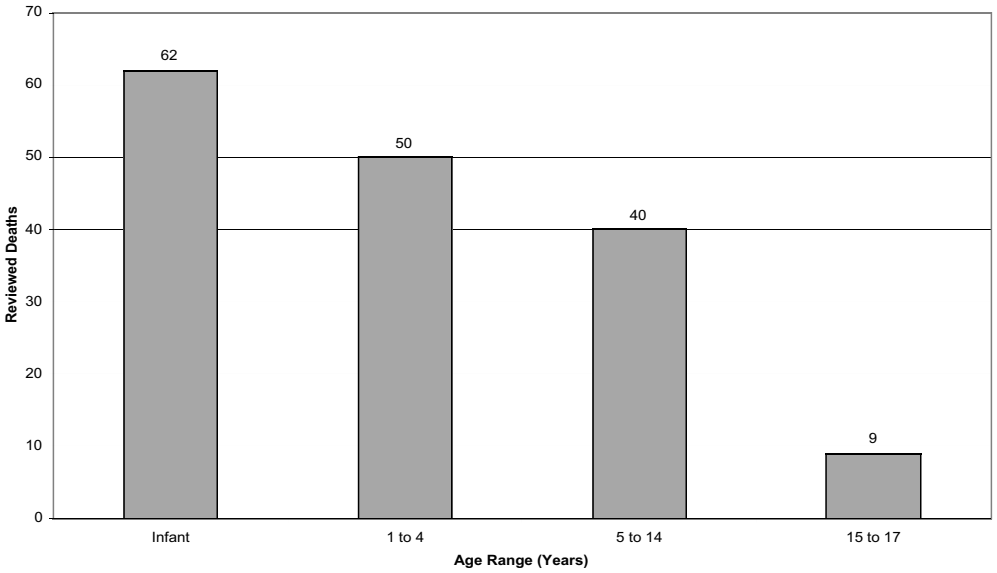
Figure 9. Relationship of Perpetrator to Decedent in Reviewed Cases with Abuse/Neglect Findings, 2003



Finding

- 52% of the identified perpetrators were the child's natural parents

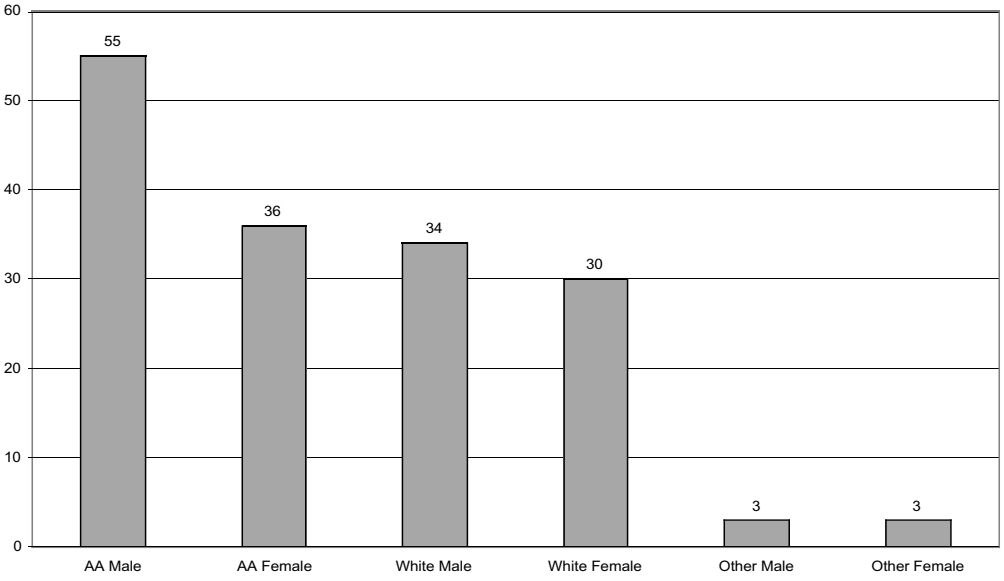
Figure 10. Age Distribution for Reviewed Deaths with Abuse/Neglect Findings, 2003



Findings

- 70% of the deaths were under the age of 5 which was a decrease from 2002 (80% were under the age of 5)
- The number of abused/neglected children <1 year old increased 51% (from 41 in 2002 to 62 in 2003)

Figure 11. Reviewed Deaths with Abuse/Neglect Findings by Race and Gender, 2003



Findings

- 57% of deaths were African American children
- 57% of victims were males with African American males representing the largest single group

Opportunities for Prevention

- Involve the local schools. One school system developed a report card insert to show parents a positive approach to dealing with disappointing grades. Utilize the schools to teach students awareness of domestic violence and child abuse
- Involve local faith communities. Help to educate faith communities on child abuse and family violence prevention
- Involve the media, specifically during child abuse awareness month by developing a press release on child abuse prevention or by involving a local celebrity/spokesperson to educate the community on child abuse awareness
- Involve legislators. Early childhood home visitation programs are effective in reducing child maltreatment among high risk families. Advocate for expansion of existing home visitation programs that include abuse/neglect issues

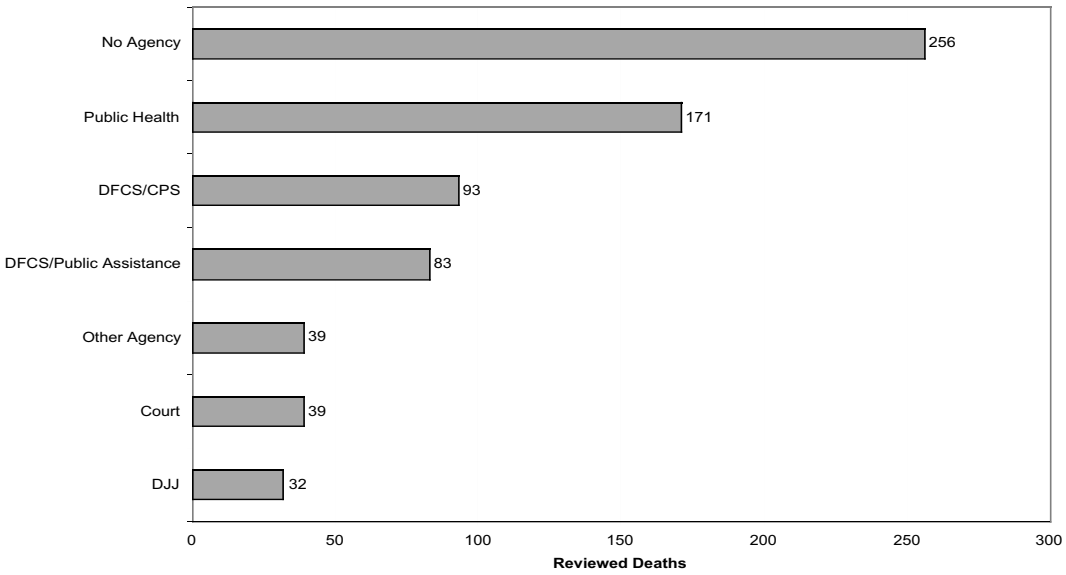
Resources:

- National Coalition Against Domestic Violence- 1-800-799-SAFE (7233) or www.ncadv.org
- Prevent Child Abuse Georgia - 1-800-CHILDREN or www.preventchildabusega.org

PRIOR AGENCY INVOLVEMENT

Fifty-five percent (366) of all 675 child fatality review reports received for 2003 indicated that 1 or more community agencies had prior interaction with the deceased child and/or his/her family. Agencies were not necessarily actively involved with children or families at the time of death. The following figures list the agencies and the number of deaths in which they were identified. A child or family was often involved with more than 1 agency; therefore, the number of involvements children/families had with agencies exceeded the number of deaths.

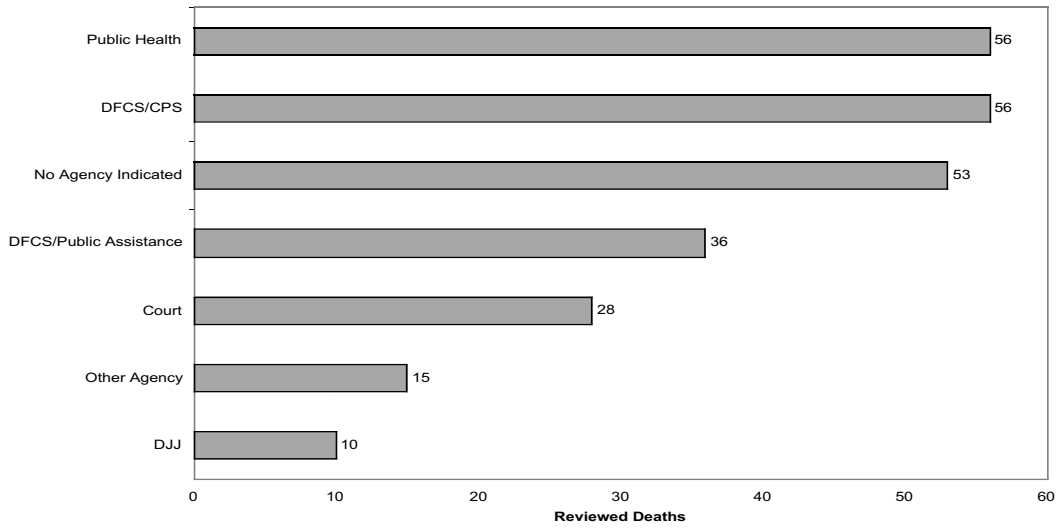
Figure 12. Agency Involvement: Reviewed Deaths with No Abuse/Neglect Findings, 2003



Findings:

- 50% of deaths (258) with no abuse findings had prior agency involvement
- Families had involvement with an average of 1.7 agencies
- 34% of families had involvement with the Department of Family and Children Services
- 33% of families had involvement with Public Health

Figure 13. Agency Involvement: Reviewed Deaths with Abuse/Neglect Findings, 2003



Findings

- 67% of deaths (108) with abuse findings had prior agency involvement
- Families had involvement with an average 1.7 agencies
- Of the 161 deaths that committees determined to be suspected or confirmed abuse/neglect, 35% (56) had prior CPS involvement
- 35% of families had involvement with Public Health
- For the 56 children/families known to Child Protective Services, 4 reports did not indicate the nature of the involvement. Involvement for the remaining 52 children/families is listed in the chart to the left

Decedent	17
Both decedent and another child in the family	9
Another child in the family, not the decedent	7
Decedent, another child in family and caretaker	8
Caretaker	5
Other child and caretaker	0
Decedent and caretaker	6

SIDS AND SUID DEATHS

SIDS represents the second leading cause of child deaths (excluding medical deaths) for all children under 18, though it only includes infants.

Sudden Infant Death Syndrome (SIDS) is the sudden, unexpected death of an apparently healthy infant under one year of age, which remains unexplained after the performance of a complete post mortem investigation, including autopsy, an examination of the death scene, and review of the case history. SIDS is by definition one of exclusion. Risk factors for SIDS include overheating, tobacco smoke, a prone sleeping position, and unsafe sleeping arrangements.

Sudden Unexplained Infant Death (SUID) is a category used by child fatality review committees for deaths that appear to be SIDS but have other risk factors that could have contributed to the infant's death. An unsafe sleeping environment is the most common risk factor for SUID deaths. Unsafe sleeping environments include a sleep surface not designed for an infant, excessive bedding, toys or decorative bumper guards, sleeping with head or face covered, or sharing a sleep surface with multiple persons or with a person who is overly tired or intoxicated.

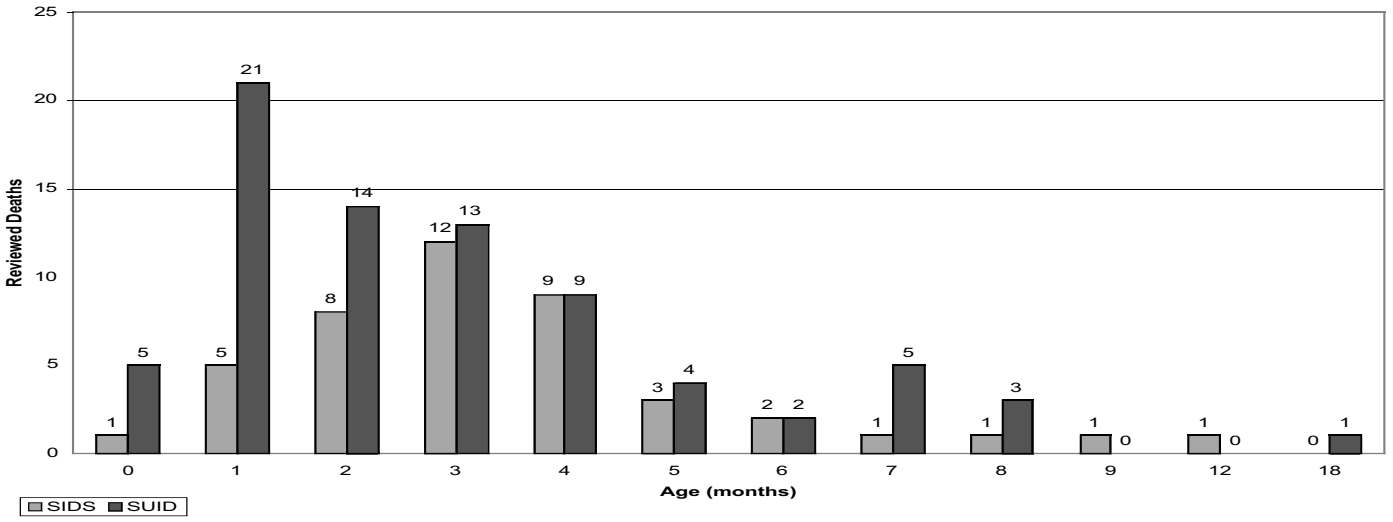
Death certificate data indicated 103 infant deaths occurred from SIDS and 15 infant deaths had SIDS listed as a contributing cause for a total of 118 infant deaths. Child fatality review committees reviewed 121 deaths determined by committees to be SIDS (44) or SUID (77).

When sleeping position was known, 27 (77%) of SIDS deaths and 40 (65%) of SUID deaths were infants sleeping on their stomach or side. Only 5 deaths determined to be SIDS were known to be sleeping on their backs in a crib.

Of the 77 SUID deaths reviewed by county committees, the following items were listed as being in contact with the child prior to his/her death: bumper guard, other person, pillow, car seat cover, stuffed toys, and a fluffy mattress.

A 2-month old African American male was placed face down on a full size bed with his 2-year-old sibling. There were pillows placed between both children to keep the 2-year-old from rolling onto the younger child. The mother slept on a futon bed in the same room. The mother awoke and found the child unresponsive.

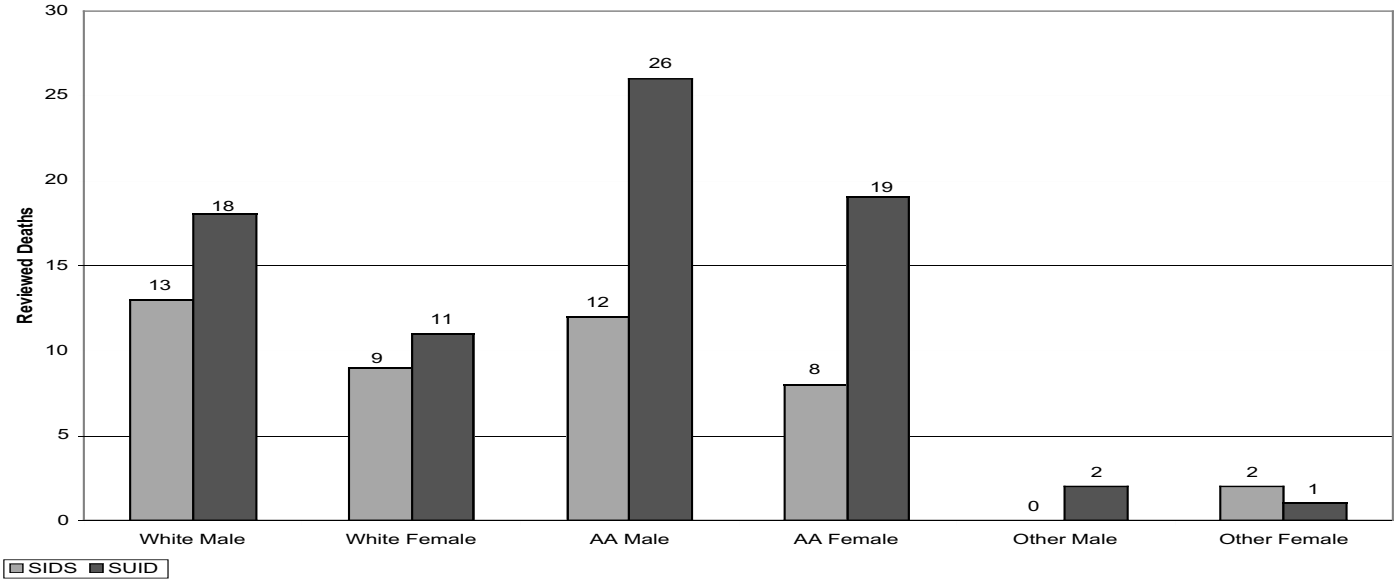
Figure 14. Reviewed SIDS/SUID Deaths by Age, 2003



Findings

- SIDS deaths peaked at 3 months of age and then declined; SUID deaths peaked at 1 month of age and then declined
- 59% of SIDS deaths and 69% of SUID deaths occurred in infants under 4 months of age

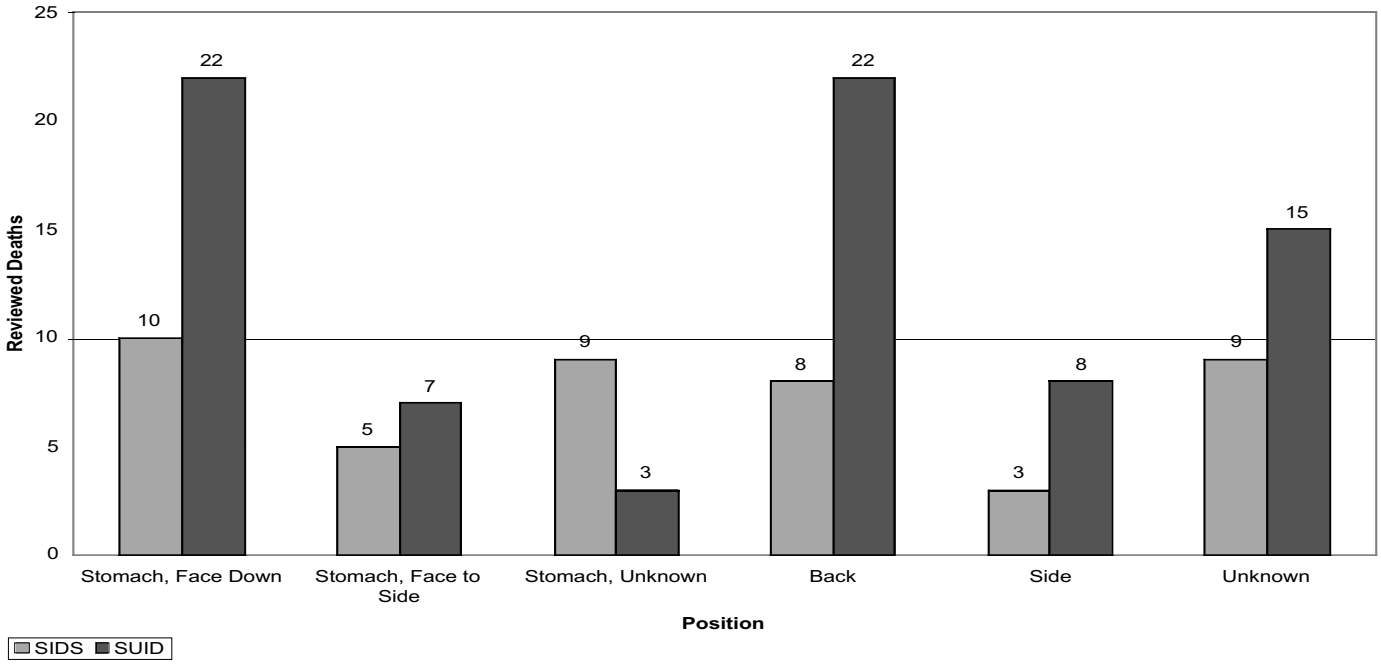
Figure 15. Reviewed SIDS/SUID Deaths by Race and Gender, 2003



Findings

- 45% of all SIDS deaths and 58% of all SUID deaths were African American infants
- 59% of all SIDS and SUID deaths were male

Figure 16. Sleeping Position of Infants who Died of SIDS/SUID, 2003



Findings

- When sleeping position was known, 69% of the SIDS deaths were infants reported to have been on their stomachs when discovered
- When sleeping position was known, 52% of the SUID deaths were infants discovered on their stomachs

Figure 17a. Location at Time of Death for Infants who Died of SIDS, 2003

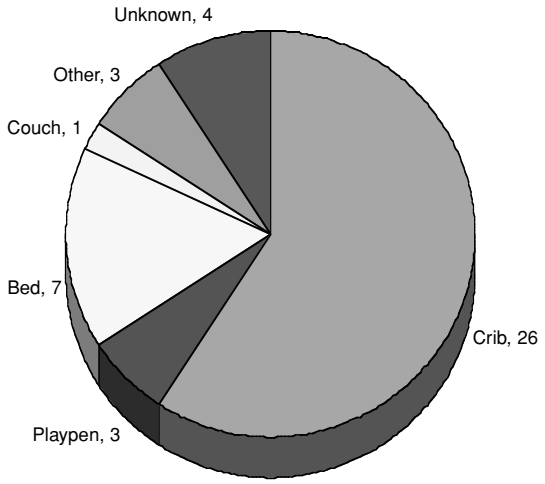
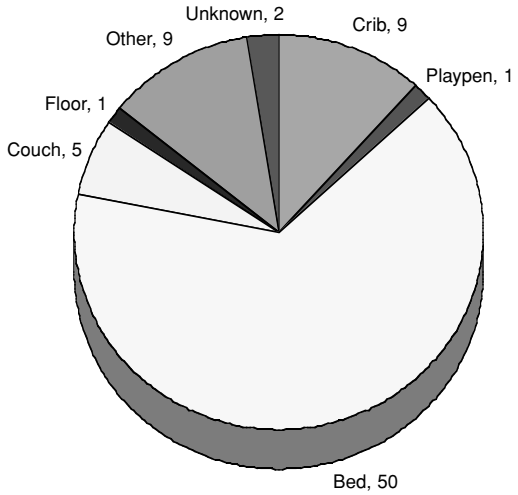


Figure 17b. Location at Time of Death for Infants who Died of SUID, 2003

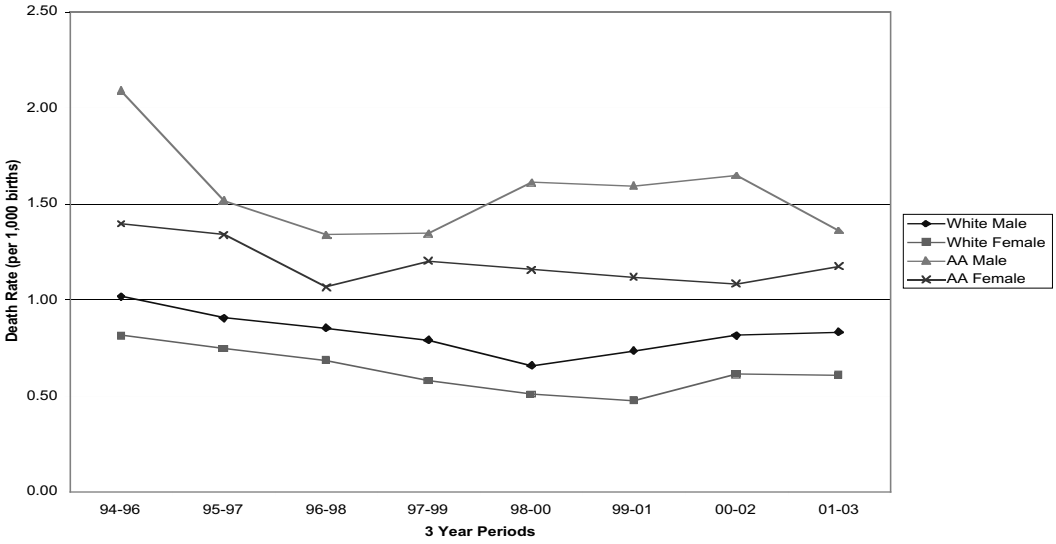


Findings

- 65% of SIDS deaths were infants reported to have been found in their cribs compared to 12% of SUID deaths
- 67% of SUID deaths were infants reported to be found in an adult bed

SIDS TRENDS

Figure 18. SIDS Death Rates per 1,000: Ages <1, Three-Year Moving Average, 1994-2003



Findings

- The three-year rates have remained fairly stable since the 1995-1997 period
- Males are about 1.5 times more likely than females to die due to SIDS
- African Americans are twice as likely as white infants to die due to SIDS

Opportunities for Prevention

- Disseminate information community wide regarding safe sleeping environments for infants. Use the American Academy of Pediatrics recommendations found at www.aap.org
- Encourage all medical personnel that have contact with caretakers of newborns to instruct them on safe sleeping practices and all other strategies to reduce the risk of SIDS
- Strengthen anti-smoking campaigns to target pregnant women and new parents

Resources

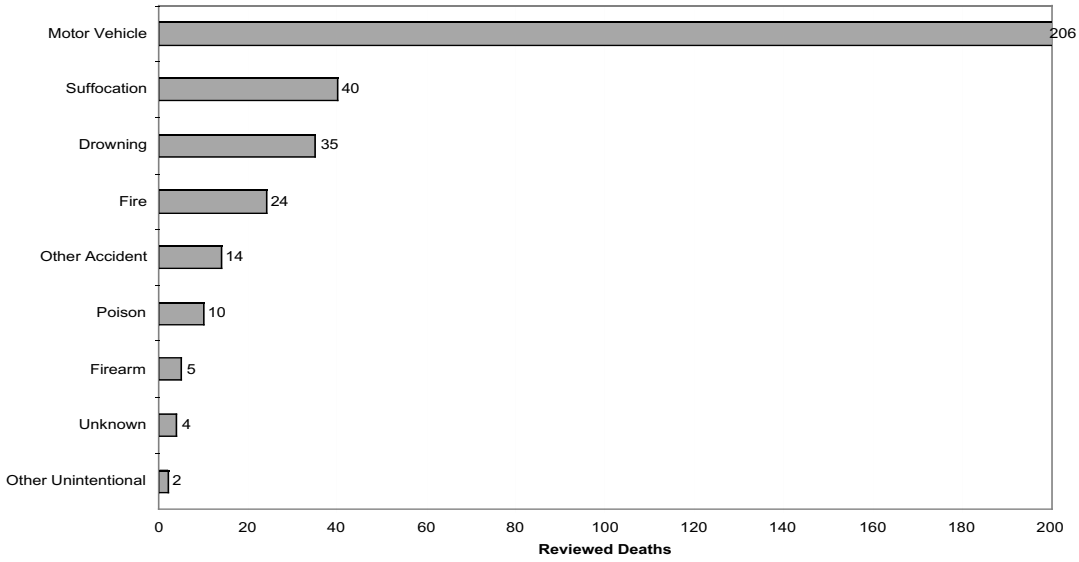
- Georgia SIDS Project - www.SIDSGa.org
- SIDS Network - www.SIDS-network.org
- The Consumer Product Safety Commission - www.cpsc.gov

UNINTENTIONAL INJURY-RELATED DEATHS

Unintentional injuries are the leading killer of children ages 1-17. Each year in the United States, approximately 7,200 children ages 14 and under are killed and another 50,000 are permanently disabled. More children ages 1-17 die from unintentional injuries than from all childhood diseases combined (National Volunteer Fire Council).

Death certificate data for Georgia indicated injuries claimed the lives of 441 children in 2003. Three hundred thirty-six (336) of those deaths were unintentional (76%). Child fatality review committees reviewed 334 injury-related deaths they determined to be unintentional. Committees could not determine the cause of 4 child deaths and could not determine the intent of 2 child deaths. Figure 19 shows the distribution of those deaths by type of injury for children ages 0-17.

Figure 19. Reviewed Unintentional Injury-Related Deaths by Cause, 2003



Findings

- 62% (206) of deaths resulted from motor vehicle-related incidents
- Suffocation deaths showed the biggest increase (from 21 in 2002 to 40 in 2003)
- 32% (107) of unintentional injury-related deaths occurred among children under the age of 5

MOTOR VEHICLE-RELATED DEATHS

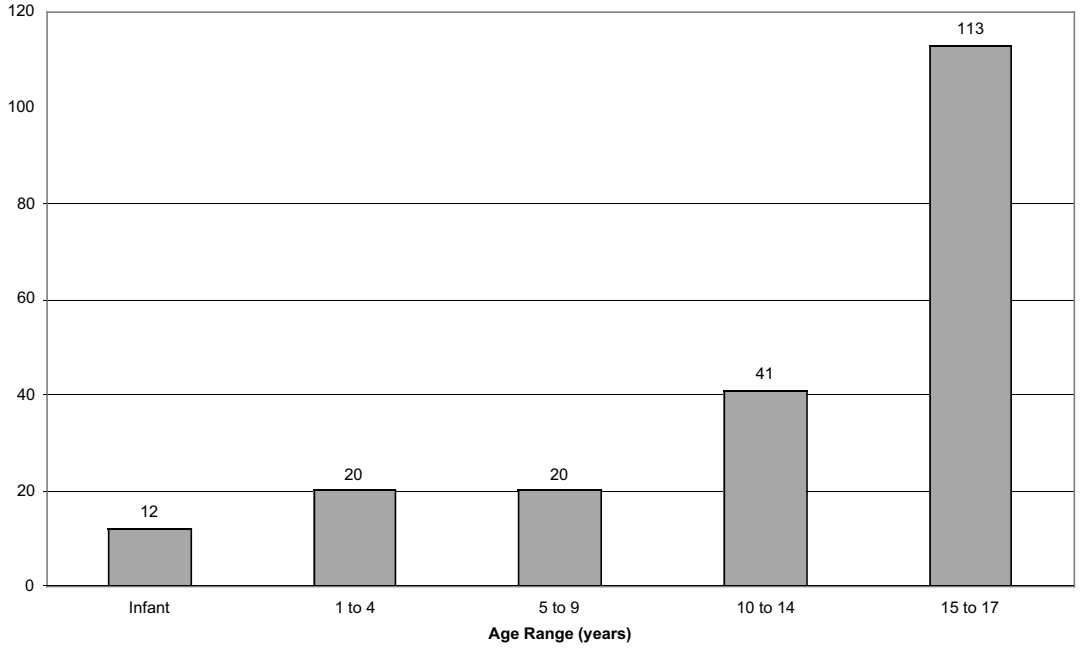
Every day an average of seven children ages 0-14 are killed, and another 866 are injured in motor vehicle crashes across the U.S., while in Georgia on average, 4 children under age 18 die each week.

Motor vehicle crashes are the leading cause of unintentional injury-related deaths for children over the age of one in the United States and Georgia. Motor vehicle fatalities include drivers and passengers of motor vehicles, pedestrians who are struck by motor vehicles, bicyclists, and occupants of any other form of transportation including all-terrain-vehicles (ATV's).

Every day an average of seven children ages 0-14 are killed and another 866 are injured in motor vehicle crashes across the U.S., while in Georgia on average, 4 children under age 18 die each week. Teenagers are about four times as likely as adults over 30 to be in a fatal crash. In 2002, (the most recent statistics available), 3,827 young people between the ages of 15 and 20 were killed on our roads in the U.S., while 324,000 were injured (nhtsa.dot.gov).

In 2003, death certificate data indicated that there were 211 motor vehicle-related child deaths. This number increased from 192 in 2002. Child fatality review committees reviewed a total of 206 motor vehicle-related deaths in 2003. Boys were almost twice as likely to die in a motor vehicle incident as girls. Of the 206 reviewed motor vehicle-related deaths, 65 were drivers, 82 were passengers, 26 were pedestrians, 12 involved ATV's, and 6 involved motorcycles. Four bicycle related deaths were the result of motor vehicle crashes and four were bicycle only crashes. Additional deaths listed as "Other" included a go-cart, riding on exterior of vehicle, a scooter, and one "back over" incident involving an infant.

Figure 20. Reviewed Motor Vehicle-Related Deaths by Age, 2003



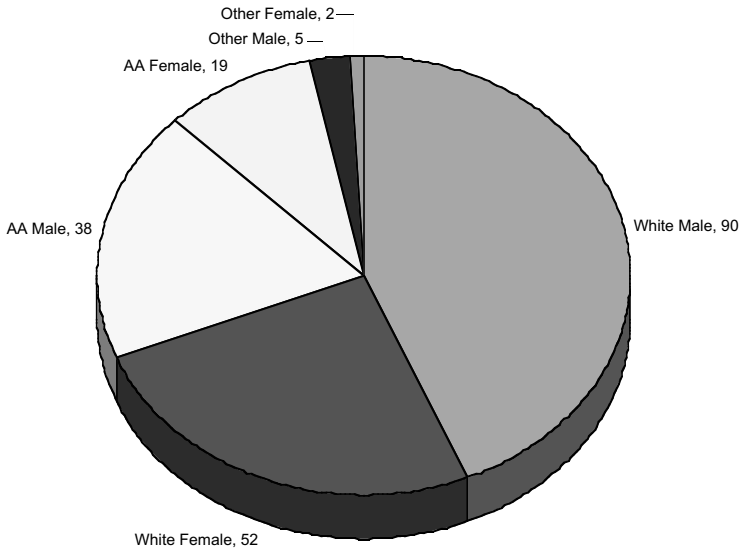
Finding

- 55% of reviewed motor vehicle-related fatalities occurred among children 15-17 years of age

Age 15	22
Age 16	43
Age 17	48

A 16-year-old driver and her 15 and 16-year-old passengers were all killed in a motor vehicle incident. Traveling home from school, the driver of the van swerved onto the right shoulder, then crossed the road and struck a tree.

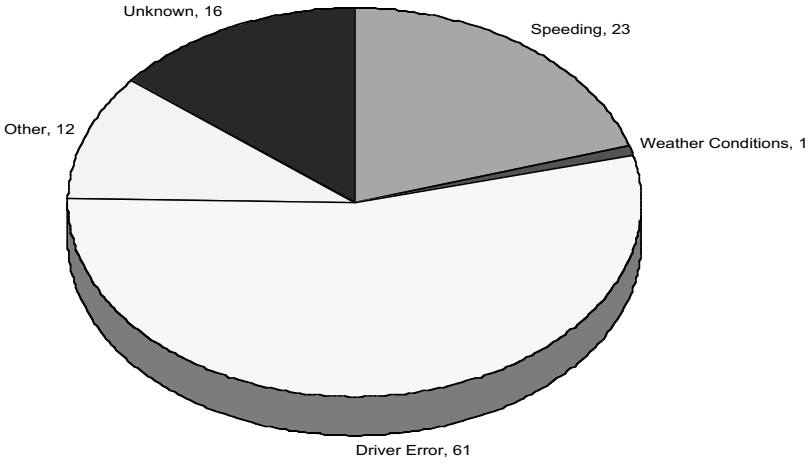
Figure 21. Reviewed Motor Vehicle-Related Deaths by Race and Gender, 2003



Findings

- 65% of all motor vehicle-related fatalities involved males
- 44% of fatalities involved white males
- 69 % of fatalities involved white children

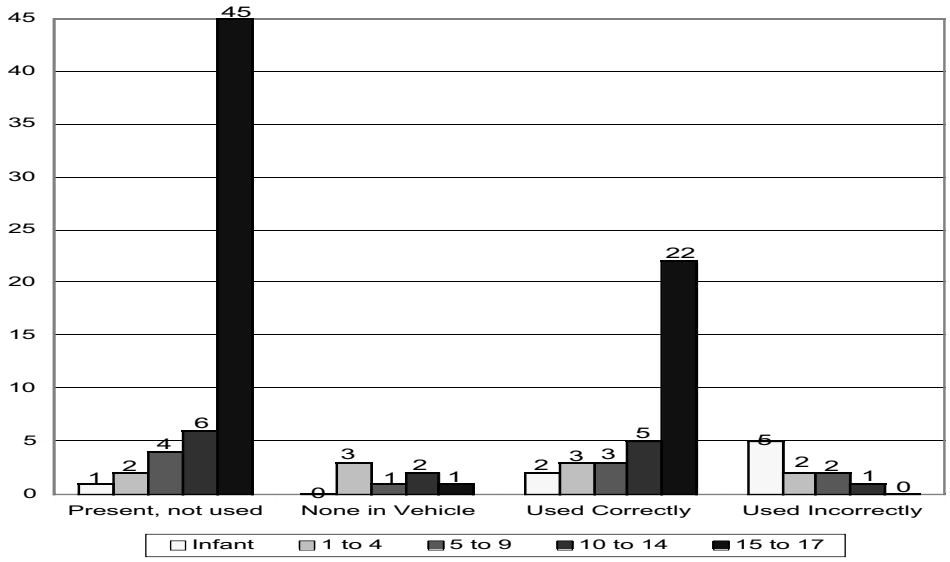
Figure 22. Primary Cause of Motor Vehicle-Related Deaths, Ages 15 -17, 2003



Finding

- Driver error was the primary cause in 63% of motor vehicle-related deaths for known causes

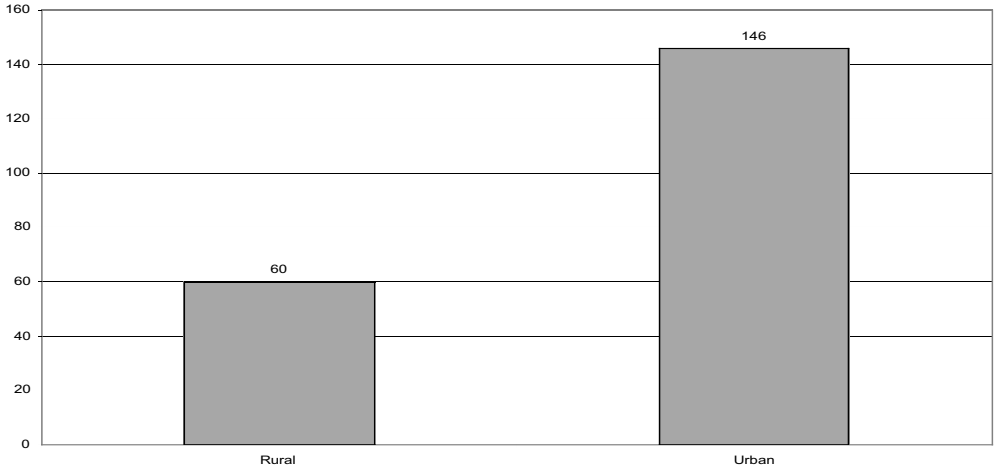
Figure 23. Reviewed Motor Vehicle-Related Deaths by Restraints Used and Age, 2003



Finding

- For the 68 teen deaths with restraint information available, 66% (45) had restraints present but not used

Figure 24. Reviewed Motor Vehicle-Related Deaths by Rural versus Urban Locale, 2003

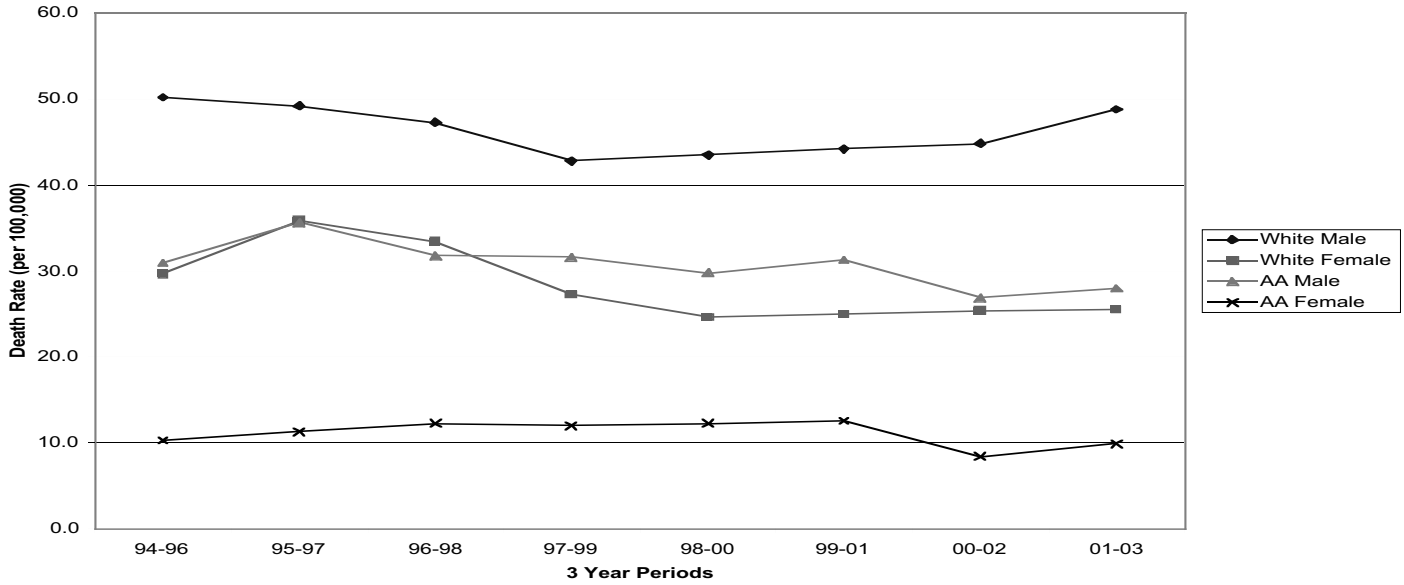


Finding

- Motor vehicle-related deaths were over represented in rural areas which accounted for 19% of the child population and 29% of motor vehicle incidents

Motor Vehicle-Related Trends

Figure 25. Motor Vehicle-Related Death Rates per 100,000: Ages 15-17, Three-Year Moving Average, 1994-2003



Findings

- Approximately 100 teens ages 15-17 die each year in motor vehicle-related incidents in Georgia
- The death rate has remained fairly stable over the 9 year period
- The total and all race-specific rates have shown little change over the last 6 years

Opportunities for Prevention

- Strengthen existing graduated licensing laws to include increased limits on the number of teen passengers allowed in a car with a teen driver
- Start or support child safety seat distribution and education programs, such as those provided by health departments and SAFE KIDS Coalitions
- Encourage auto dealerships to provide informational resources about the proper installation and usage of child safety seats, booster seats and seat belts when selling new and used vehicles
- Promote and encourage public safety programs for ATV's. Work with local dealerships to encourage the production of informational resources regarding education and safety of ATV's. Include information about wearing proper safety equipment, including a helmet, and riding only on designated trails and areas
- Encourage strict enforcement of seatbelt and child restraint laws by judiciary and law enforcement. Consider "offenders programs" through the court system as an educational alternative to fines

Resources

- Kids 'N Cars - www.kidsncars.org
- National Highway Transportation Safety Administration – www.nhtsa.dot.gov
- Safe Kids - www.safekids.org
- Georgia Highway Safety - www.gohs.state.ga.us

DROWNING DEATHS

Drowning remained the second leading cause of injury-related deaths among children ages 1 to 14 despite a 40% decline in the childhood drowning death rate from 1987 to 2001.

Drowning remains the second leading cause of injury-related death among children ages 1 to 14. In 2001, 859 children ages 0-14 died from drowning (CDC, 2003). In Georgia, drowning also ranked second as a leading cause of injury death. Males have a drowning rate two to four times that of female children. Toddlers, especially boys under age four, are at highest risk of drowning. Contrary to what many people believe, child drowning is a silent death. The belief that a drowning child will resurface several times is false. There is often very little noise to alert anyone that the child is in trouble, especially in the case of very small children (Safe Kids).

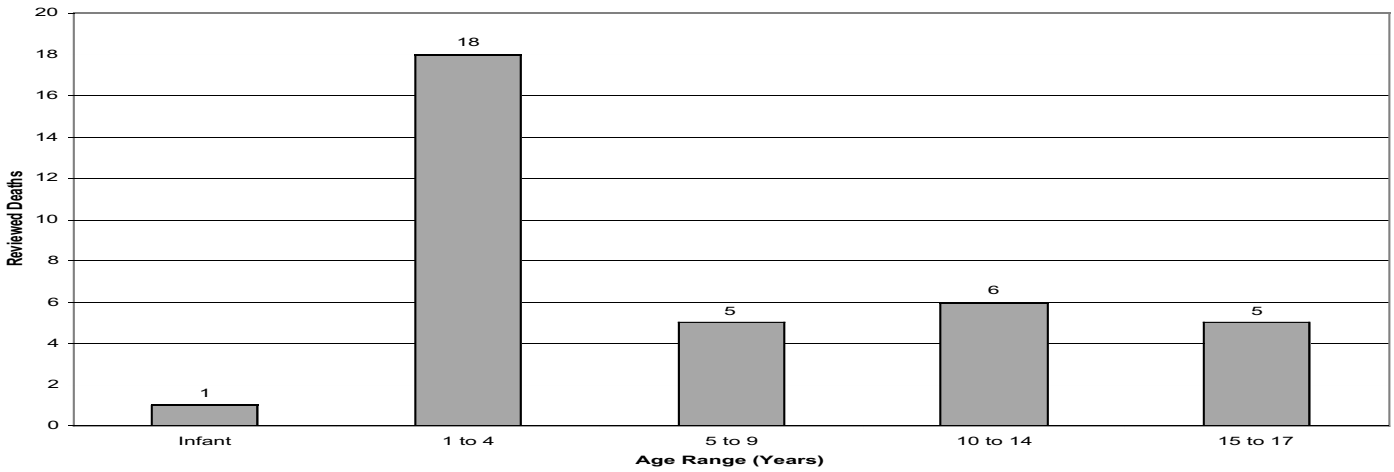
Drowning among infants under the age of one typically occurs in residential bathtubs. Most drowning incidents among children 1 through 4 years old occur in residential swimming pools. It is important to note that children can drown in as little as one inch of water; therefore, are at risk of drowning in numerous places such as wading pools, buckets, ditches, toilets and hot tubs (Safe Kids).

Death certificate data indicated 37 child fatalities occurred from drowning. This is a decrease from 44 drowning deaths in 2002. Child fatality review committee members reviewed a total of 35 drowning deaths.

Lack of supervision or a brief lapse in supervision is known to be a critical factor in childhood drowning. The use of a certified personal floatation device is also a well-established effective means of prevention. Only one child reviewed by child fatality review committees was wearing a floatation device, and when information about supervision was known, 70% of children were considered by committees to be inadequately supervised. Sixty-three percent (63%) of reviews indicated the child entered the water unattended.

A 2-year-old white male drowned in a community swimming pool. The child was not being adequately supervised, as his mother was preoccupied with cleaning the house. The decedent was gone for more than 10 minutes before his mother realized he had left the house. The child was able to walk across the street and enter a pool through a gate that had been propped open by painters.

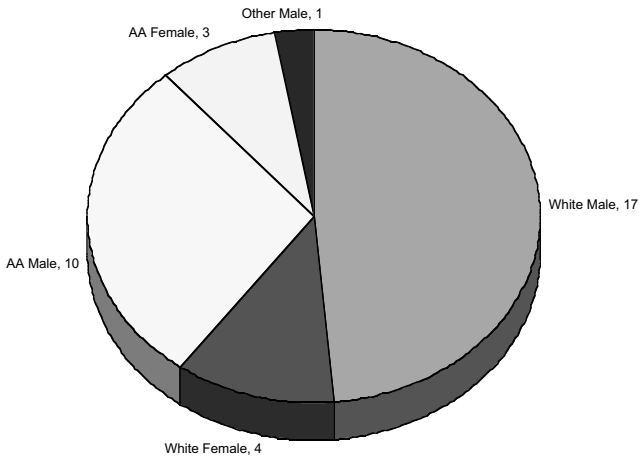
Figure 26. Reviewed Drowning Deaths by Age, 2003



Findings

- 54% of drowning victims were under the age of 5
- 31% were 10 years of age or older

Figure 27. Reviewed Drowning Deaths by Race and Gender, 2003



Findings

- 80% of all drowning victims were male
- 60% of all drowning victims were white

Findings

- The 2 deaths indicated as "other" occurred in a septic tank and a drainage ditch
- The number of drowning deaths in pools increased from 16 in 2002 to 19 in 2003
- The number of drowning deaths in natural bodies of water decreased by 10 from 17 in 2002 to 7 in 2003

Figure 28. Reviewed Deaths By Place of Drowning, 2003

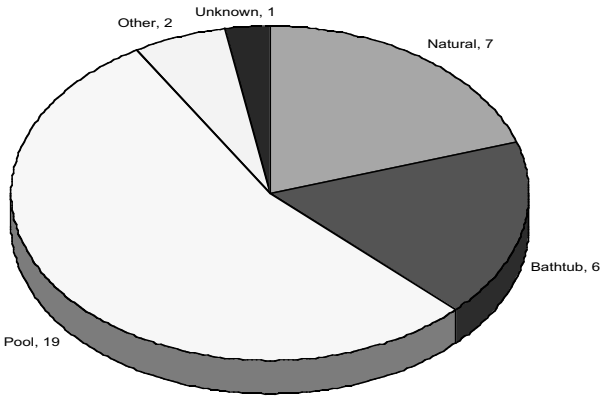
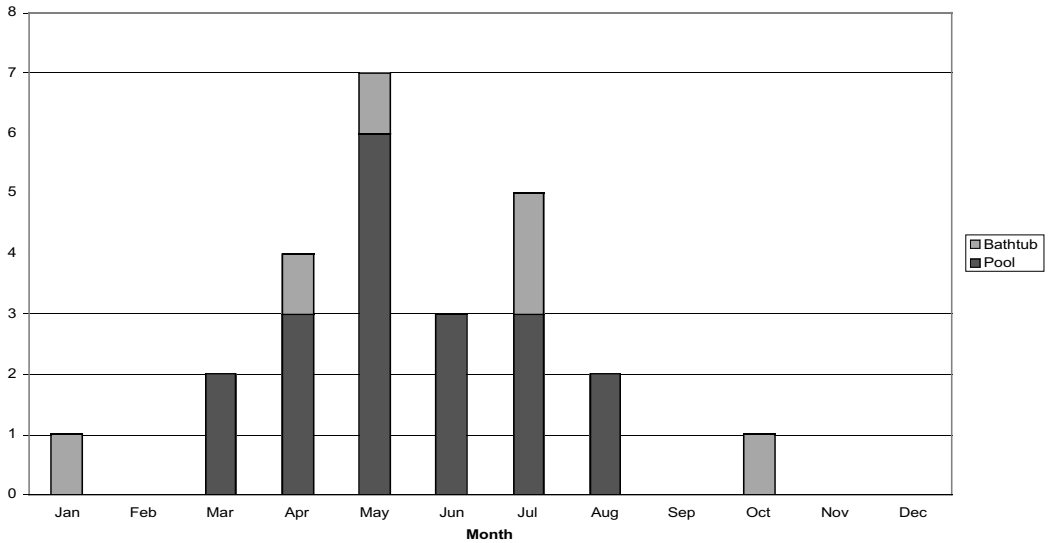


Figure 29. Deaths Due to Drowning in Pools versus Bathtubs By Month of Occurrence, 2003

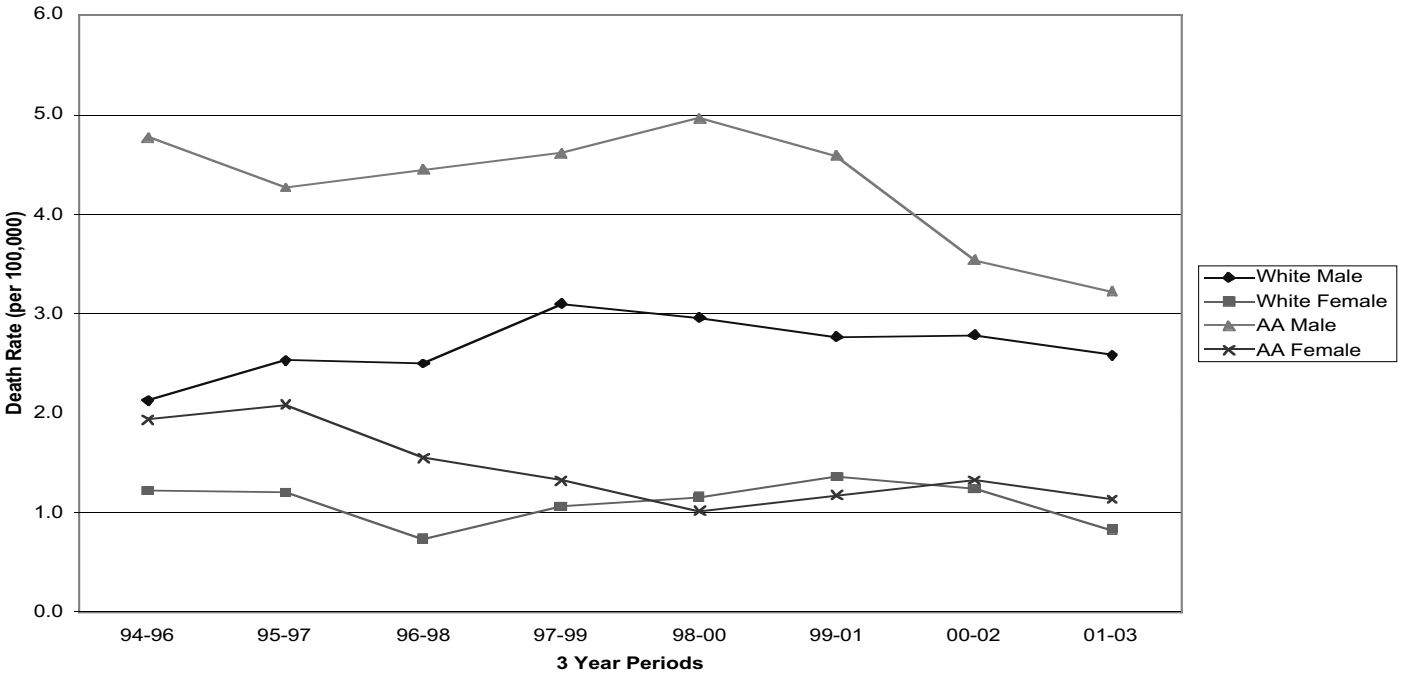


Findings

- Of 21 reviewed drowning deaths in bathtubs or pools occuring from April throught August, 17 deaths (71%) occured in a swimming pool
- Unlike drowning deaths in pools, reviewed deaths due to drowning in bathtubs were consistent throughout the year

Drowning Trends

Figure 30. Drowning Death Rates per 100,000: Ages <18, Three-Year Moving Average, 1994-2003



Findings

- African American males have the highest rate of drowning deaths
- Over the past 10 years, an average of 45 children drowned each year in Georgia

Opportunities for Prevention

- Disseminate information about the importance of supervising children especially around bodies of water including bathtubs, private swimming pools, and public bodies of water
- Encourage caregivers to enforce the consistent use of Personal Flotation Devices (PFDs) in potentially hazardous situations. While parents recognize the importance of PFD use, they do not always require their children to wear PFDs or model safe behavior for their children
- Require 4 sided isolation fencing at least 5 feet high and equipped with self-closing and self-latching gates for public and private pools statewide
- Encourage more children and parents community wide to enroll in swimming classes taught by a certified swimming instructor. Although the majority of parents (82 percent) agree that all children should take swimming lessons by age 8, 37 percent of parents of children ages 5 to 14 report that their child has never taken swimming lessons
- Promote supervision by an adult who can swim and make sure all supervisors learn basic rescue techniques, including CPR

Resources

- Center for Disease Control and Prevention: Water Related Injuries - www.cdc.gov
- Clear Danger, A National Study of Childhood Drowning and Related Attitudes and Behaviors, April 2004 at http://www.safekids.org/NSKW
- The National Spa and Pool Institute - www.nspi.org

FIRE-RELATED DEATHS

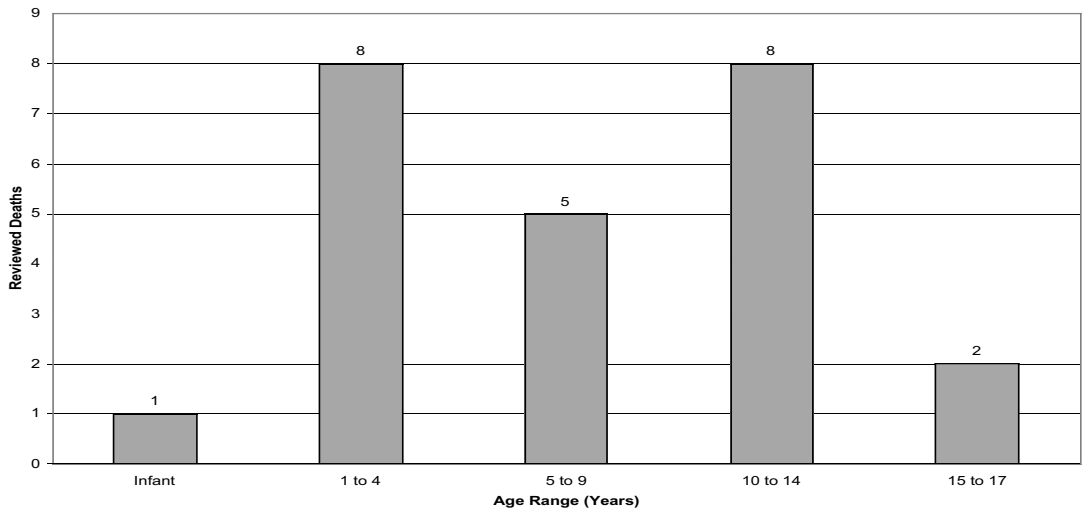
Children five and under are at the greatest risk for home fire-related death and injury, with a fire death rate more than twice the national average for total population.

Each year in the United States more than 600 children ages 14 and under die in fires; and nearly 47,000 are injured in fires. Fire and burns are the fifth leading cause of unintentional injury-related death among children ages 14 and under. The South has the highest fire-related death rate in the country, 21 percent higher than the national average. Young children, especially those ages five and under, are at the greatest risk from home fire-related death and injury, with a fire death rate more than twice the national average. Over 80% of fire deaths occur in residences, and most residential fires occur in older, wood-frame housing (Safe Kids).

Death certificate data indicated 25 child fatalities occurred from fire or burn-related deaths. This is an increase from 22 in 2002. Child fatality review committee members reviewed a total of 24 fire-related child deaths. Twenty-four (24) children died in 16 fire incidents. Seven incidents resulted in more than one child dying.

Three-year-old and one-year-old siblings died of carbon monoxide poisoning. Investigation revealed one of the two children was playing with a cigarette lighter and started the fire. The two children were unable to escape on their own.

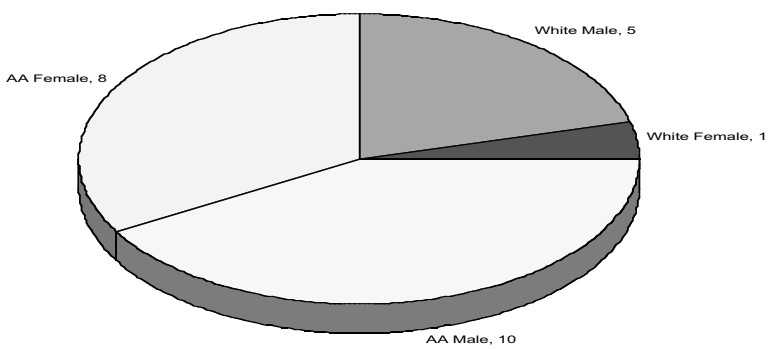
Figure 31. Reviewed Fire-Related Deaths by Age, 2003



Findings

- 38% of fire victims were under the age of 5
- 58% were under 10 years of age

Figure 32. Reviewed Fire-Related Deaths by Race and Gender, 2003

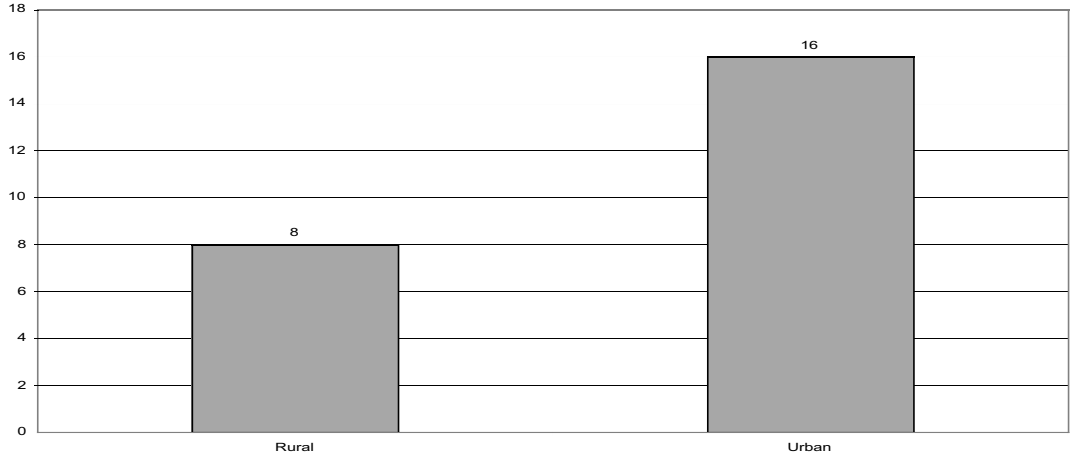


Findings

- 75% of fire victims were African American
- 63% of fire victims were male

Smoke alarms and sprinkler systems are crucial factors in reducing fire and burn deaths. The chances of dying in a residential fire decreases by over 71% if a smoke alarm is present and 62% if a sprinkler system is present. A fire escape plan is also an important prevention strategy, however, one national survey found only 53% of Americans have a family escape plan and of those, only 16% have practiced it. When information was available regarding the presence of smoke alarms, 78% of alarms were not in working order.

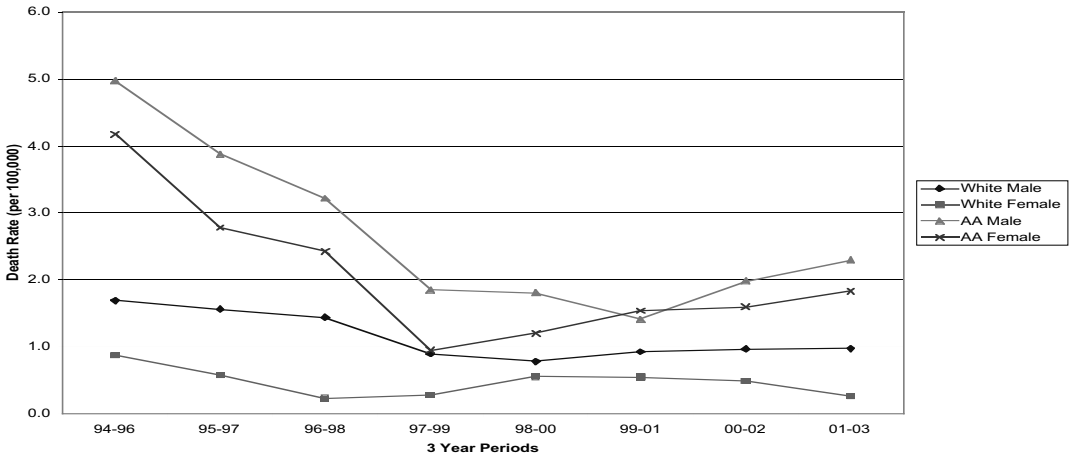
Figure 33. Reviewed Fire-Related Deaths by Rural versus Urban Locale, 2003



Finding

- 33% of fire-related deaths of children occurred in rural Georgia where 19% of the child population resides

Figure 34. Fire-Related Deaths per 100,000: Ages <18, Three-Year Moving Average,1994-2003



Findings

- There have been an average of 21 fire-related deaths in Georgia over the past 7 years
- African American children are twice as likely as white children to die in fires

Opportunities for Prevention

- Promote the installation of smoke alarms on every level and in every sleeping area. Test them once a month. Replace the batteries once a year and replace alarms every 10 years
- Encourage rental agreements that make landlords responsible for ensuring that rental properties have working smoke detectors
- Implement a community campaign to promote the prevention of fire/smoke inhalation deaths. Include, as part of your campaign, information on scalding and burn related deaths
- Encourage families to develop and practice a home fire escape plan
- Teach families to store matches and lighters out of chidren's reach

Resources

- United States Fire Administration – www.usfa.fema.gov
- Fire Safe –www.firesafe.com
- Georgia Firefighters Burn Foundation - gfbf.org
- The Fire Marshal's/Insurance Commissioner's Office –www.gainsurance.org
- Safe Kids - www.safekids.org

INTENTIONAL INJURY DEATHS

The total number of deaths listed on death certificates as resulting from homicide and suicide (99) indicated an increase in deaths from intentional causes (83 in 2002). In 2003, local child fatality review committees reviewed a total of 101 deaths determined to have resulted from intentional causes. Committees determined more deaths were the result of suicide than those indicated on death certificates.

More children 0-4 years of age in the United States now die from homicide than from infectious diseases or cancer.

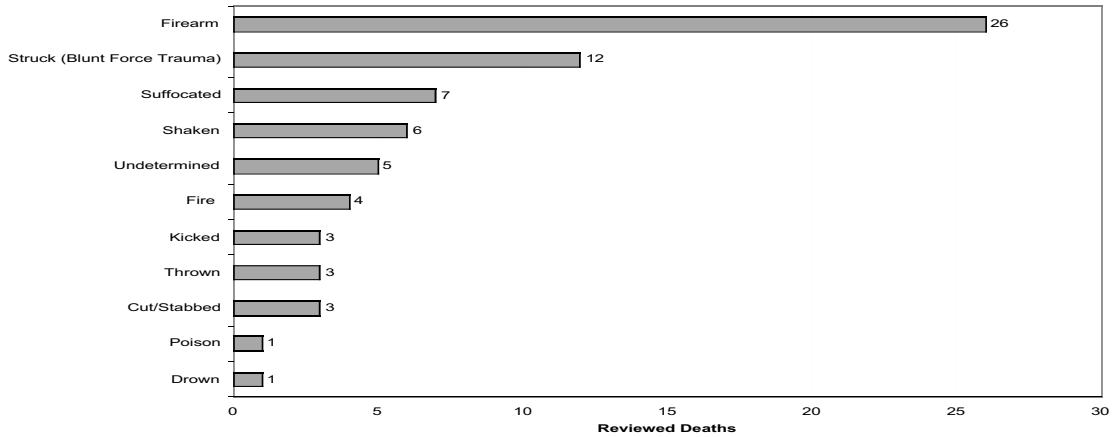
HOMICIDE

Nationally, homicide is the only major cause of childhood death that has increased in incidence during the past 30 years. Homicide is the second leading cause of death for young people ages 10 to 19 and the fourth leading cause of death for children ages 1 to 14 years in the United States. Homicide claims the lives of more teenagers in the United States than any cause, other than accidents (Office of Juvenile Justice and Delinquency Prevention). According to FBI data, more than 5 juveniles per day die of homicide in the United States, ranking the U.S. first among developed countries in homicides of juveniles. The U.S. rate is 5 times higher than the rate of the 25 other developed countries combined. From 1995-1999 Georgia was ranked 10th in the nation for child handgun homicide victims.

Most homicides to young children resulting from beating or suffocation are from family members. More children 0-4 years of age in the United States now die from homicide than from infectious diseases or cancer (Office of Juvenile Justice and Delinquency Prevention).

In 2003, child fatality review committees reported 71 homicide deaths, which is an 11% increase from 2002 (64). The figure below represents reviewed homicide deaths by circumstance of death.

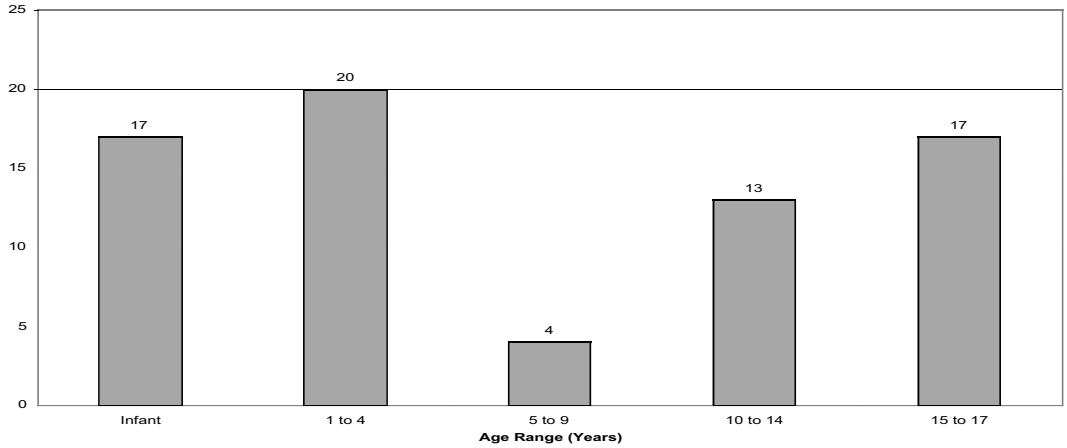
Figure 35. Reviewed Homicide Deaths by Circumstance of Death, 2003



Findings

- Firearms were determined to be involved in 26 (37%) of the 71 homicide deaths
- 18 deaths (25%) were attributed to blunt force trauma or violent shaking

Figure 36. Reviewed Homicide Deaths by Age, 2003



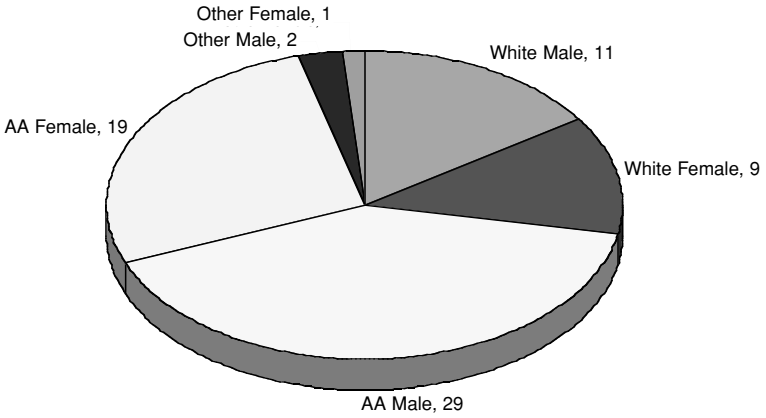
Findings

- 24% of the 71 reviewed homicides were youth ages 15 to 17 (10 of the 17 deaths were caused by a firearm)
- 52% (37) of homicide victims were under 5 years of age (7 of the 37 were victims of Shaken Baby Syndrome or blunt force trauma)

Findings

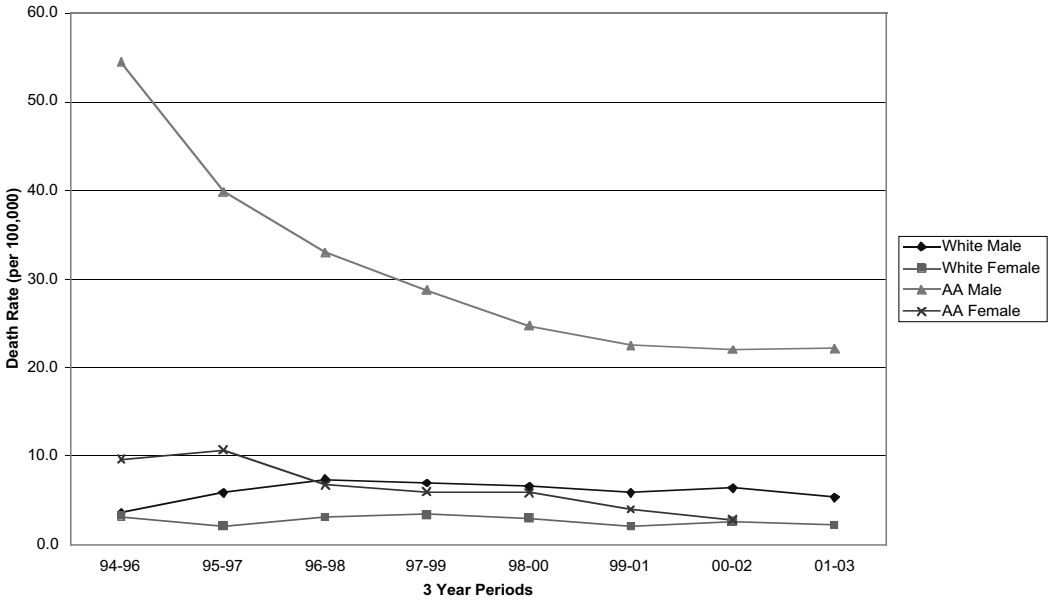
- 41% of homicide victims were African American males
- 68% of all homicide victims were African American

Figure 37. Reviewed Homicide Deaths by Race & Gender, 2003



Homicide Trends

Figure 38. Homicide Death Rates per 100,000: Ages 15-17, Three-Year Moving Average, 1994-2003



Findings

- African American males are 5 times more likely than all other teens to be homicide victims (97 in 2003)
- African American males (15-17) make up 18% of the teen population, but account for over 50% of all teen homicides
- The decrease in teen homicides over the 10 year period is largely due to the decrease in African American male homicides
- In the 1994-1996 period, the average number of African American male (15-17) homicides was approximately 30; however, in the latest 3 year period (2000-2003), the average number is down to 14

An 8-year old African American male died of blunt force trauma. Both parents hit the child with several unknown objects. The parents were charged with murder.

Opportunities for Prevention

- Encourage in school and after school programs teaching conflict resolution and anger management
- Educate parents on effective parenting practices
- Educate children on how to resist negative peer pressure
- Educate parents on how to be pro-active in preventing bullying among children

Resources

- Prevent Child Abuse Georgia - 1-800-CHILDREN or www.preventchildabusega.org
- Office of Juvenile Justice and Delinquency Prevention- http://ojjdp.ncjrs.org or 1-800-851-3420

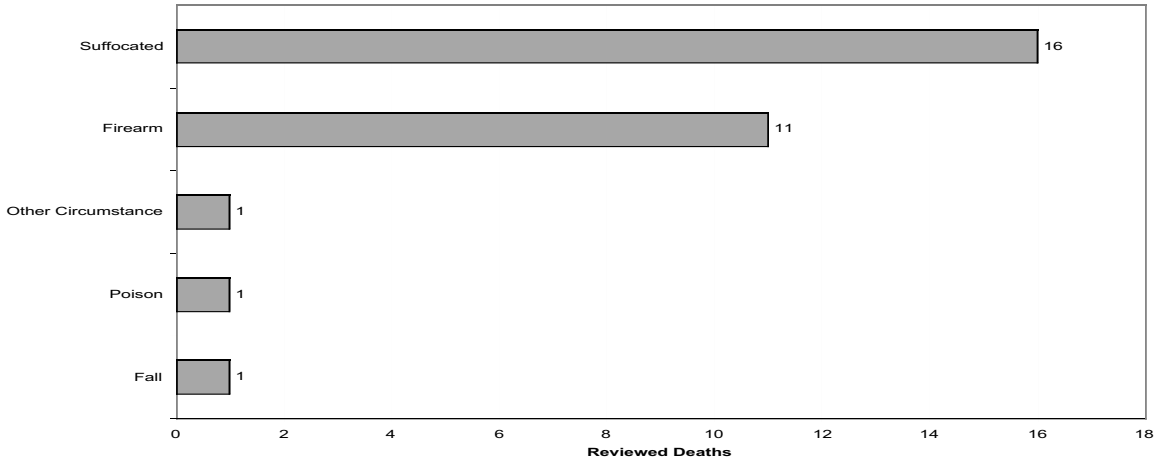
SUICIDE DEATHS

Males are four times more likely to die from suicide than females, with rates highest among whites.

Nationally, while the incidence of suicide has slowly decreased, suicide among young people has increased. Suicide is the third leading cause of death for 15 to 24 year olds, and the sixth leading cause of death for 5 to 14 year olds. Males are four times more likely to die from suicide than females, with rates highest among whites. In 2001, firearms were used in 54% of youth suicides. Adolescents and young adults often experience stress, confusion, and depression from situations occurring in their families, schools, and communities. Often suicide is seen as the solution. There are many factors that place youth at risk, including depression, substance abuse, behavioral problems, availability of a gun, and previous attempts.

In 2003, local child fatality review committees reviewed 30 deaths of children ages 10 - 17 that committed suicide. This is a 12% increase of reviewed suicide deaths from 2002 (25). A total of 28 suicide deaths for children ages 10 -17 were reported in death certificate data (2 deaths were not determined to be suicide because intent was unknown). The most common circumstance of suicide deaths for 10 - 14 year olds was suffocation, while the most common for 15 - 17 year olds was firearm (See Figure 39). A handgun was used in 82% (9) of firearm suicide deaths.

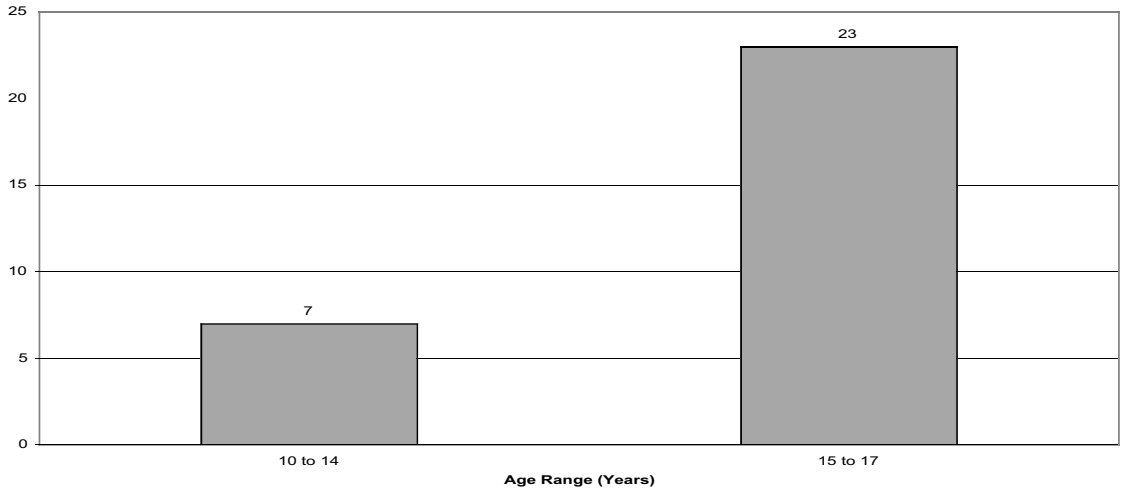
Figure 39. Reviewed Suicide Deaths By Circumstances of Death, 2003



Findings

- Firearms were determined to be involved in 37% of the 30 suicide deaths
- 16 suicide deaths (53%) were attributed to suffocation

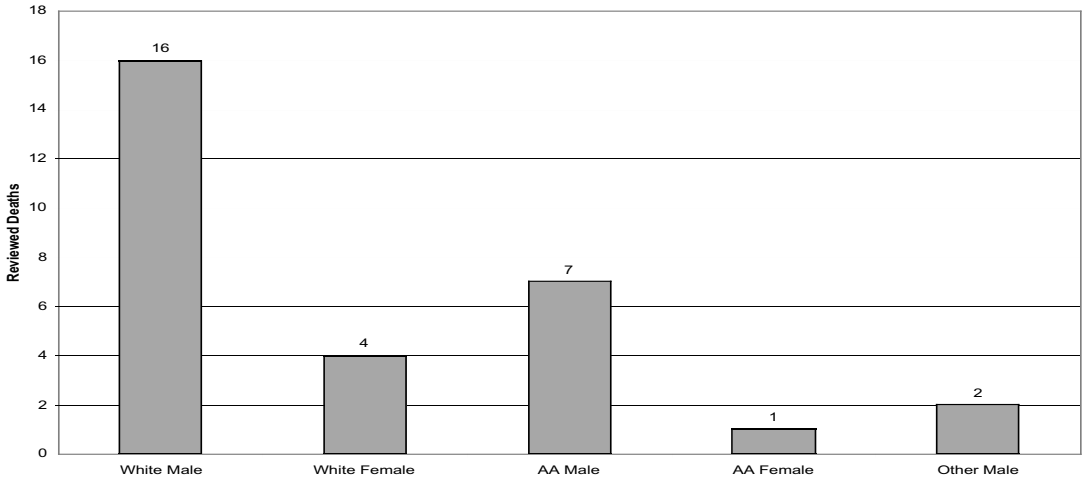
Figure 40. Reviewed Suicide Deaths By Age, 2003



Findings

- 23% (7) of reviewed suicide victims were 10-14
- The youngest victims (2) were 12 years of age

Figure 41. Reviewed Suicide Deaths By Race and Gender, 2003



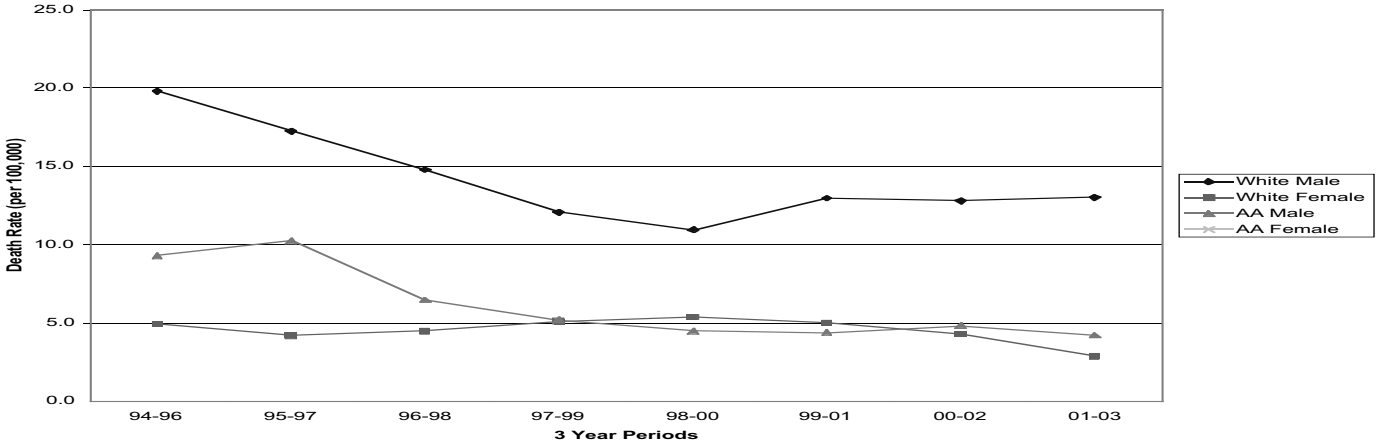
Findings

- 53% (16) of suicide victims were white males
- Suicide among females overall decreased from 36% in 2002 to 17% in 2003
- Suicide deaths among all males increased from 64% in 2002 to 83% in 2003

A 15-year old African American male committed suicide by a gunshot wound to the head. The child had very poor grades in school, passing only one subject. School officials knew he had been absent 21 to 30 days during just one semester, as well as his involvement with drugs.

Suicide Trends

Figure 42. Suicide Death Rates per 100,000: Ages 15-17, A Three-Year Moving Average, 1994-2003



Findings

- The average number of suicides over the last 5 three year periods has been constant
- Males are 4 times more likely to commit suicide than females
- Rate of suicide in white males is significantly higher than in any other race/sex category
- The number of suicide deaths for African American females is small, therefore a rate should not be reported

Opportunities for Prevention

- Reduce the risk factors associated with suicide through screening and evaluation of mental heath and substance abuse disorders along with positive support groups
- Raise awareness in the community by minimizing the stigma associated with suicide
- Increase public and private resources to support funding for at-risk children
- Support strict legislation on safety locks for firearms

Resources

- National Suicide Hotline 1-800 SUICIDE (1-800-784-2433)
- Focus Adolescent Services-1-877-362-8727 or www.focusas.com

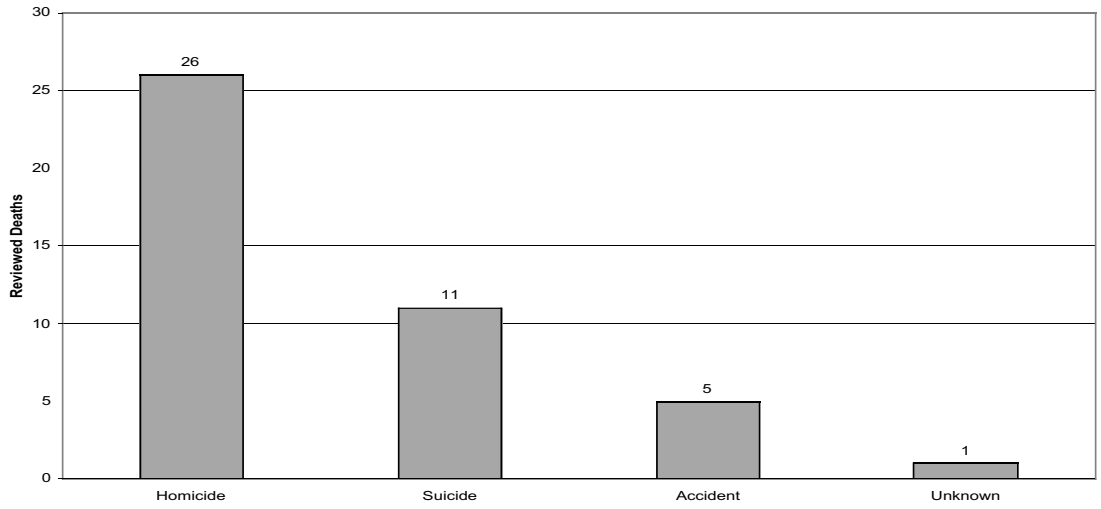
FIREARM-RELATED DEATHS

Firearm injuries are the second leading cause of death for young people in the United States 10 to 19 years of age.

For every child killed, four more sought care for a firearm wound. Firearms caused 77% of violent deaths in schools. Approximately 50% of all homes in the United States contain a firearm, and over 50% of handguns in homes are loaded. When alcohol/drugs are used and a gun is available, the risk for violence rapidly increases. In a youth suicide study, victims who used firearms were about five times more likely to have been drinking than those who used other means. In a study of firearm-associated murders among family members, almost 90% of the offenders and victims had used alcohol or drugs before the killings (American Academy of Child Adolescent Psychiatry).

In Georgia, death certificate data indicated firearms caused a total of 43 deaths. Firearm and homicide related deaths are generally thought to be more prevalent in urban areas; however, the incidence of firearm and homicide related deaths is higher in rural areas based on child population in Georgia. Child fatality review committees reviewed 43 firearm related deaths. Child fatality review reports ask for information not available on death certificates, including source of the firearm, type of firearm, who was using the firearm at the time of death, and the age of the firearm handler. This information provides important guidance for prevention.

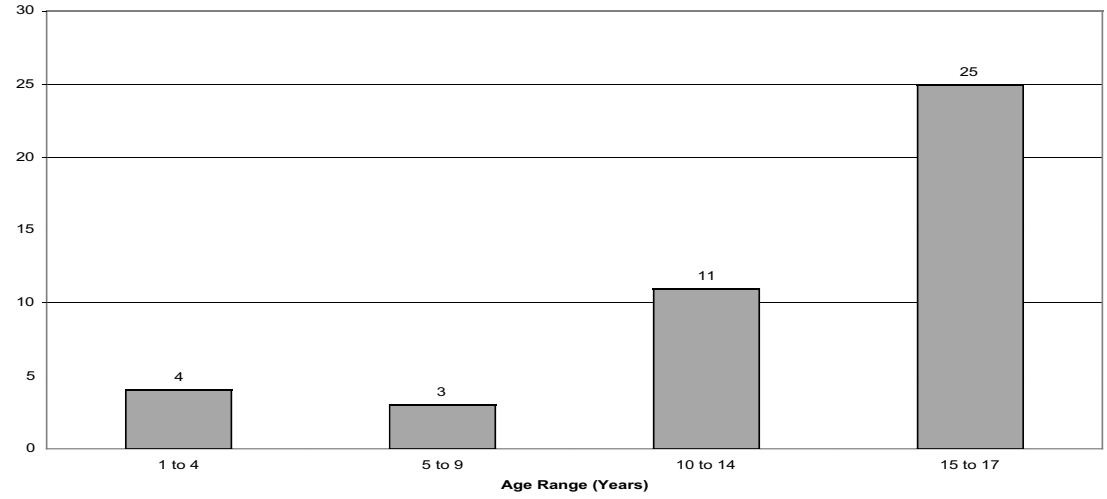
Figure 43. Reviewed Firearm-Related Deaths By Circumstances of Death, 2003



Findings

- 60% of firearm related deaths were homicides
- A large majority of firearm deaths (86%) among children were intentional

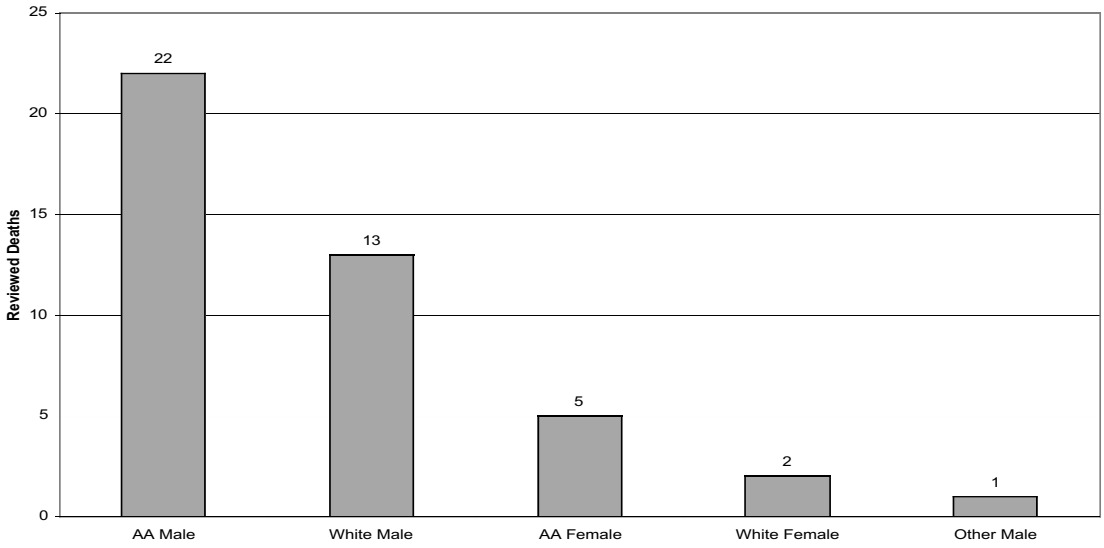
Figure 44. Reviewed Firearm-Related Deaths By Age, 2003



Findings

- 58% of child firearm deaths were concentrated among 15 to 17 year olds (21 of the 25 firearm deaths in this age group were intentional- 10 homicides and 11 suicides)
- The largest decrease among age groups for firearm-related deaths was for 15 to 17 year olds (40%)

Figure 45. Reviewed Firearm-Related Deaths By Race and Gender, 2003



Findings

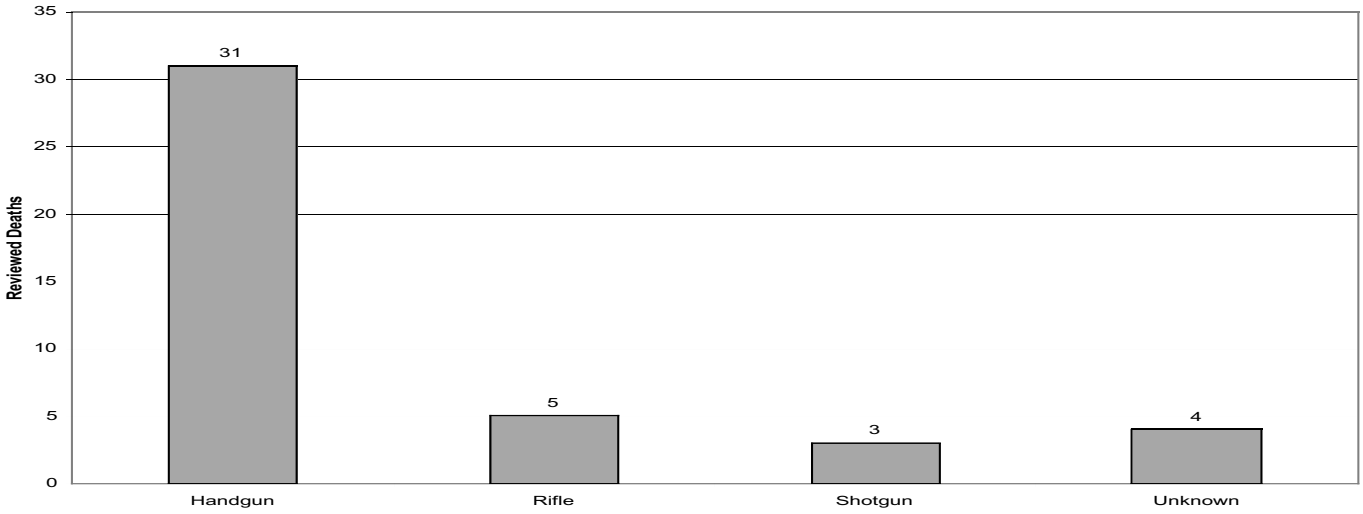
- African American children accounted for 63% of reviewed firearm-related deaths
- Males accounted for 84% of all reviewed firearm deaths

Source of Firearm

- The source of the firearm was noted as "Unknown" for 47% of the reviewed deaths
- 17 of the deaths with an indicated source identified a person known to the youth (parent, relative, friend) to be a source of the firearm
- A parent was the source of the firearm for 7 of the 11 suicides (64%)

Type of Firearms

Figure 46. Reviewed Firearm-Related Deaths By Type of Firearm, 2003



Findings

- A handgun was used in 31 (79%) of the 39 deaths for which the type of firearm was known
- Of the 30 reviewed suicides, 11 (37%) involved firearms:
  - 9 (82%)= handgun
  - 2 (18%)= rifle
- Of the 71 reviewed homicides, 37 % (26) involved firearms:
  - 20 (77%) = handgun
  - 2 = rifle
  - 1 = shotgun
  - 3 = other type

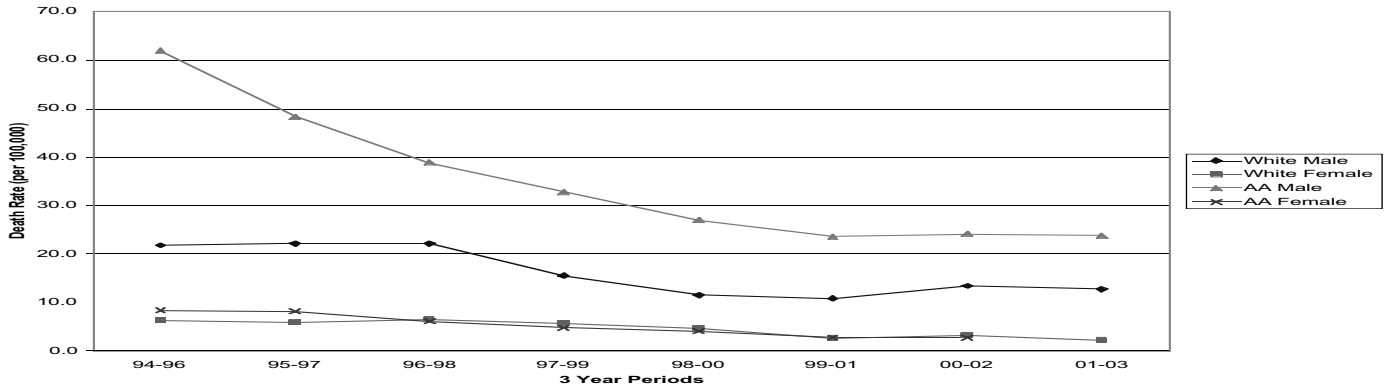
Usage
- In 84% of firearm deaths (36), the shooter was aiming at himself or someone else
- 5 deaths were unintentional
- The intent of 1 firearm-related death was unknown

Storage
- The gun was unsecured in 13 of the 16 deaths with information on gun storage

Age of Handler
- The shooter was under 18 in 17 (55%) of the 31 deaths that identified the age of the shooter
- 14 of the 18 deaths with a shooter 18 or older were homicides (78%)

Firearm Trends

Figure 47. Firearm-Related Death Rates per 100,000: Ages 15-17, Three-Year Moving Average, 1994-2003



Findings
- The average annual number of deaths due to firearms decreased from 105 in years 2000-2002 to 98 in years 2001-2003
- There has been a continued decrease in the rate of deaths due to firearms in the 2001-2003 period after a steady drop over the previous six three-year periods
- The rate in African American males seems to have reached a plateau after a dramatic decrease from 1994-1996 through 1997-1999

A 15-year-old male died of suicide. Even though he spoke of suicide in the past, the parents still had several unsecured guns in the home. The decedent shot himself with one of those guns.

Opportunities for Prevention
- Educate young children not to touch guns when unsupervised by an adult and to tell an adult if they find a gun
- Check with your local police for advice about safe storage and gunlocks
- Support intervention strategies in the school system such as conflict resolution, alternatives to violence and educational programs for kids and teens
- Remind children that pellet and BB guns can also hurt and kill. They should be used only under adult supervision. The Consumer Products Safety Commission recommends only kids 16 years of age or older use BB guns

Resources
- The Speak Up Campaign helps to educate on the prevention of school shootings. Kids can contact 1-866-SPEAK UP, the nations only anonymous hotline for kids to report weapon threats in their schools
- Contact Kids Health at www.kidshealth.org for resource information to distribute within the community on gun safety

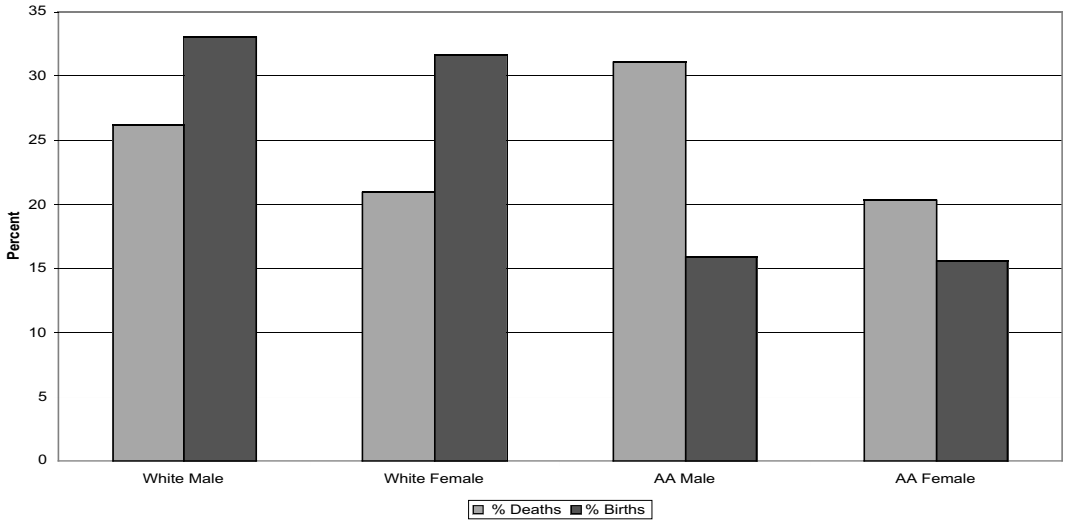
RACE, ETHNICITY AND DISPROPORTIONATE DEATHS

According to a work group for Racial and Ethnic Disparities in infant mortality, for more than 20 years research has indicated that there are significant disparities in infant mortality rates in the United States. To date, much of the research has focused on disparities between infant mortality rates for white and African American infants. More recently, research has begun to focus on disparities related to other racial and ethnic subgroups. The Department of Health and Human Services documents that infant death rates among African Americans, American Indians, Alaska Natives, and Hispanics/Latinos in 1998 were all above the national average of 7.2 deaths per 1,000 live births. The infant mortality rate for African Americans (13.8 per 1000 births) was more than double the rate for white infants (6.2)

Additionally, the workgroup discussed many of the known risk factors associated with low birth weight and infant mortality which include conditions such as socio-economic status, ethnicity and obstetric history. Lifestyle behaviors such as cigarette smoking, maternal nutrition and use of alcohol and other drugs may also be a strong influence. Research has also shown that lack of health insurance coverage is a risk factor for adverse birth outcomes and infant mortality. These risk factors must be taken into consideration when planning prevention strategies.

Data are presented in this report by race and gender for each type of death to enable more detailed analysis. The terms, "white", "African American" (AA) and "Other" are used to identify racial groups throughout the report. "Other" refers to children of Asian, Pacific Islander, Native American origin or multiracial. Death certificate data includes ethnicity information that can identify children of Hispanic origin. One hundred twenty five (125) of 126 deaths identified as Hispanic indicated the race as "white". The remaining death was reported as "Black". The total number of Hispanic infant and child deaths has decreased from 133 in 2002 to 126 in 2003.

Figure 48. Deaths to Children <1 and Percent of Population in Georgia, By Race and Gender, 2003

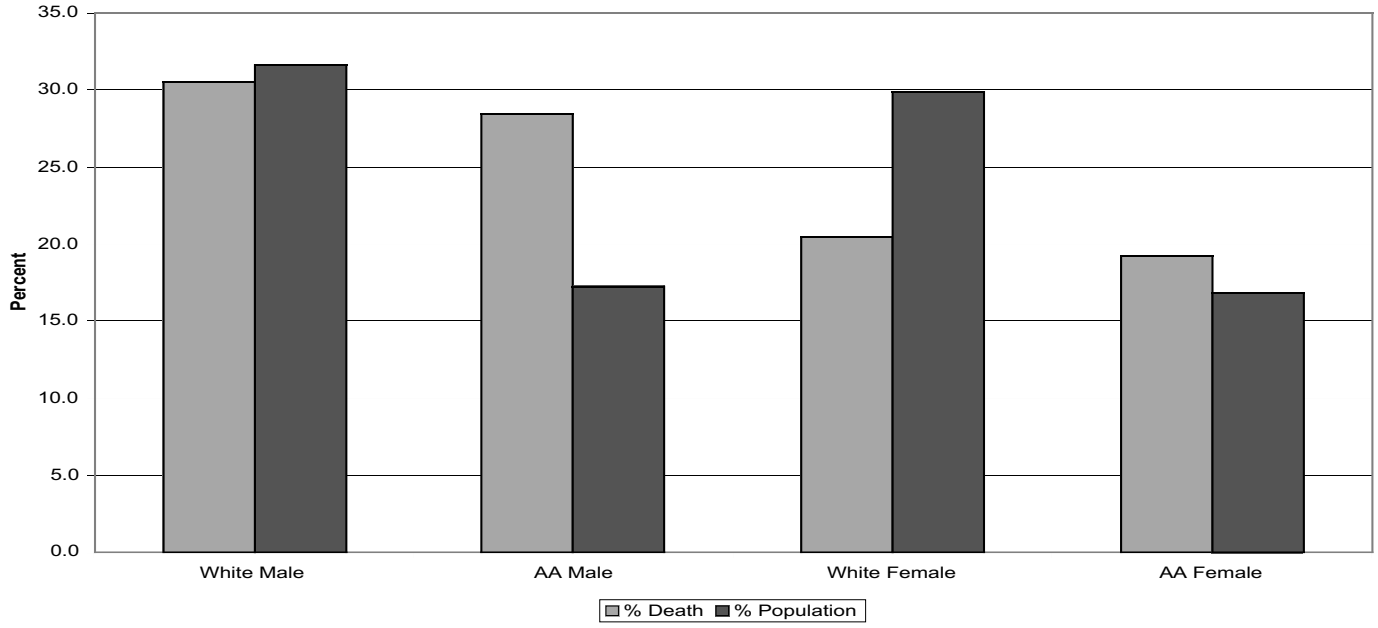


Finding

- A disproportionate number of deaths occurred among African American infants

	% of Deaths	% of Population
All AA Infants	52	32
AA Male Infants	31	16
AA Female Infants	21	16

Figure 49. Deaths to Children 1-17 and Percent of Population in Georgia, By Race and Gender, 2003



Finding

- Males between the ages of 1-17 are about 50% more likely to die than females in the same age group

	% of Deaths	% of Population
All Males 1-17	60	51
All AA Males 1-17	29	17
White Males 1-17	31	32

Opportunities for Prevention

- Educate mothers about the dangers of cigarette smoking and alcohol/drug use while pregnant. Cigarette smoking is considered the single most preventable factor for low birth weight and growth retardation
- Encourage prenatal education for both mother and father, specifically for ethnic groups new to American society
- Promote more culturally sensitive outreach efforts by Public Health for medical care to minority groups

Resource

- United States Department of Health and Human Services 1-877-696-6775 or www.os.dhs.gov

THE HISTORY OF CHILD FATALITY REVIEW IN GEORGIA

1990 - 1993

Legislation established the Statewide Child Fatality Review Panel with responsibility for compiling statistics on child fatalities and for making recommendations to the Governor and General Assembly based on the data. It established local county protocol committees and directed that they develop county-based written protocols for the investigation of alleged child abuse and neglect cases. Statutory amendments were adopted to:

- Establish a separate child fatality review team in each county and determine procedures for conducting reviews and completing reports
- Require the Panel to:
  1) Submit an annual report documenting the prevalence and circumstances of all child fatalities with special emphasis on deaths associated with child abuse
  2) Recommend measures to reduce child fatalities to the Governor, the Lieutenant Governor, and the Speaker of the Georgia House of Representatives
  3) Establish a protocol for the review of policies, procedures and operations of the Division of Family and Children Services for child abuse cases

1996 - 1998

- The Panel established the Office of Child Fatality Review with a full-time director to administer the activities of the Panel
- Researchers from Emory University and Georgia State University conducted an evaluation of the child fatality review process. The evaluation concluded that there were policy, procedure, and funding issues that limited the effectiveness of the review process. Recommendations for improvement were made to the General Assembly
- Statutory amendments were adopted to:
  1) Identify agencies required to be represented on child fatality review teams, and establish penalties for non-participation
  2) Require that all child deaths be reported to the coroner/medical examiner in each county

1999 - 2001

- Child death investigation teams were initially developed in four judicial circuits as a pilot project, with six additional teams later added. Teams assumed responsibility for conducting death scene investigations of child deaths that met established criteria within their judicial circuit
- Statutory amendments were adopted which resulted in the Code section governing the Child Fatality Review Panel, child fatality review committees, and child abuse protocol committees being completely rewritten. This was an attempt to provide greater clarity and a more comprehensive, concise format
- The Panel's budget was increased

2002 – 2004

- The Panel published and distributed a child fatality review protocol manual to all county committee members
- Statutory amendments were adopted which resulted in the following:
  1) Appointment of District Attorneys to serve as chairpersons of local committees in their circuits
  2) Authority of the Superior Court Judge on the Panel to issue an order requiring the participation of mandated agencies on local child fatality review committees. Failure to comply would be cause for contempt
  3) Authority of the Panel to compel the production of documents or the attendance of witnesses pursuant to a subpoena
  4) Director of the Division of Mental Health added as a member of the Panel
- Funding was secured and an on-line reporting system was established for both the child fatality review report and the coroner/medical examiner report
- A collaboration was established between the Office of Child Fatality Review and the National Center for Child Death Review
- A Prevention Advocate was added, by policy, to all child fatality review committees
- A quarterly newsletter was initiated for all child fatality review committee members, and other relevant parties
- Five additional child death investigation teams were added

APPENDIX A
CRITERIA FOR CHILD DEATH REVIEWS

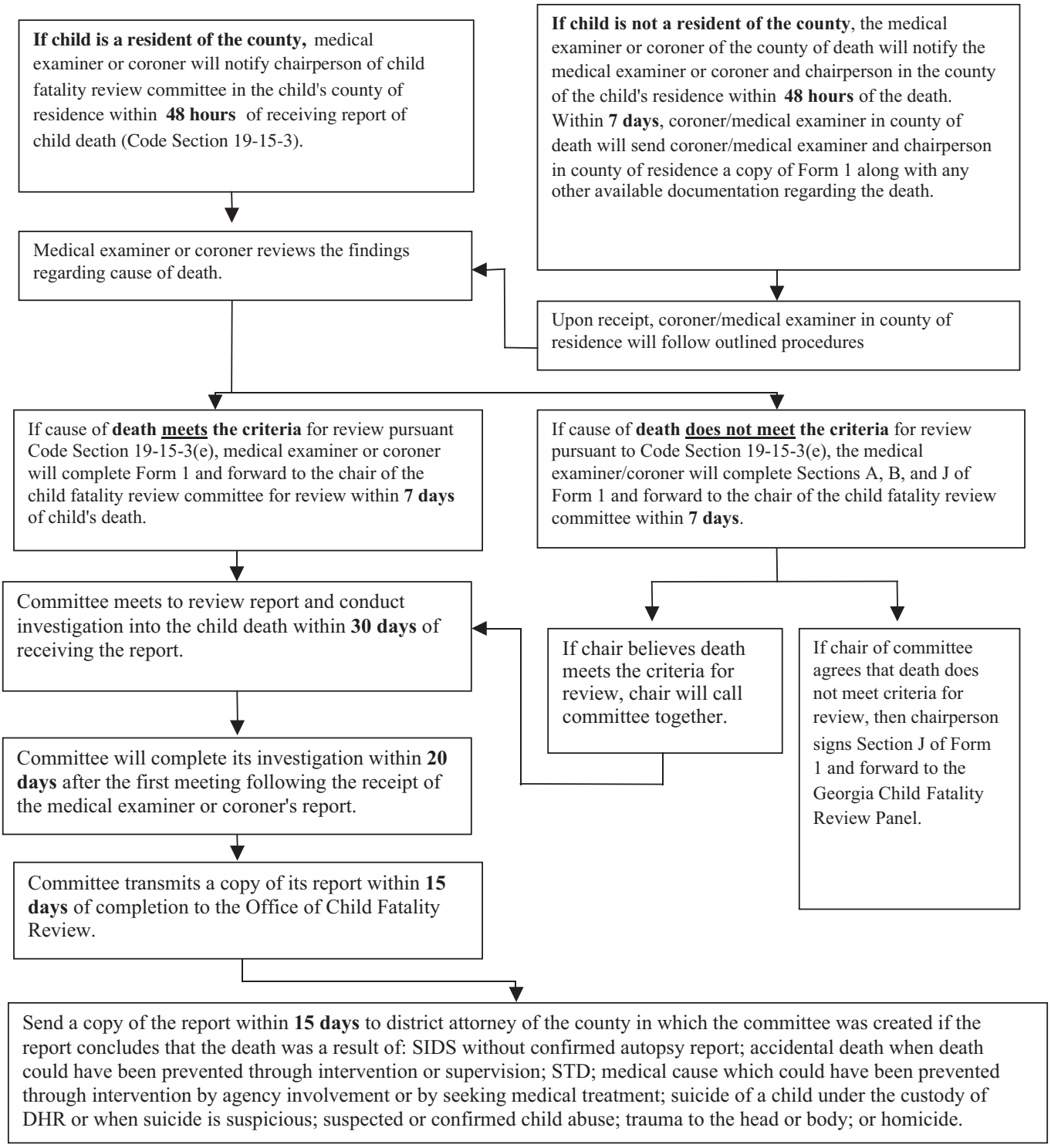
Child Fatality Review Committes are required to review the deaths of all children under the age of 18 that meet the criteria for a coroner/medical examiner's investigation.

"Eligible" Deaths or Deaths to be Reviewed by Child Fatality Review Committes O.C.G.A. 19-15-3(e)

Death eligible for review by local review committees are all deaths of children ages birth through 17 as a result of:

1. Sudden Infant Death Syndrome
2. Any unexpected or unexplained conditions
3. Unintentional Injuries
4. Intentional injuries
5. Sudden death when the child is in apparent good health
6. Any manner that is suspicious or unusual
7. Medical conditions when unattended by a physician
8. Serving as an inmate of a state hospital or a state, county, or city penal institution

APPENDIX B
CHILD FATALITY REVIEW TIMEFRAMES AND RESPONSIBILITIES



APPENDIX C.1 Total Child Fatalities Based on Death Certificate

Age	Cause of Death	White Male	White Female	AA Male	AA Female	Other Male	Other Female	Total
Infant (Age<1)								
	Drowning			3				3
	Fire/Burns				1			1
	Homicide	2	4	2	6			14
	Medical Causes	251	199	302	188	10	6	956
	Vehicle Accident	5	3	2				10
	Other Accident	1	2	1				4
	Other SIDS	3	3	4	5			15
	SIDS	27	22	27	27			103
	Suffocation	6	4	9	6			25
	Unknown Intent			1				1
	Unknown	6	4	7	1			18
	Total	301	241	358	234	10	6	1,150

Age	Cause	White Male	White Female	AA Male	AA Female	Other Male	Other Female	Total
1 to 4								
	Drowning	9		6	2			17
	Fire/Burns	3	1	1	4			9
	Homicide	3	4	8	4			19
	Medical Causes	23	12	19	18	2	2	76
	Vehicle Accident	9	3	5	2			19
	Other Accident	1	1		2			4
	Poisoning			2				2
	Suffocation	1	2	2	2		1	8
	Unknown Intent		1	1				2
	Unknown		2	1	1			4
	Total	49	26	45	35	2	3	160

Age	Cause	White Male	White Female	AA Male	AA Female	Other Male	Other Female	Total
5 to 14								
	Drowning	5	1	3	2			11
	Fire/Burns	1		8	4			13
	Homicide	4	1	8	6			19
	Medical Causes	41	29	25	25		2	122
	Vehicle Accident	27	17	14	5			63
	Other Accident	5	1	3				9
	Poisoning		1					1
	Suffocation		1					1
	Suicide	2	1	3				6
	Unknown Intent	3						3
	Unknown	1			1			2
	Total	89	52	64	43		2	250

Age	Cause	White Male	White Female	AA Male	AA Female	Other Male	Other Female	Total
15 to 17								
	Drowning	4	1	1				6
	Fire/Burns	1			1			2
	Homicide	6		12	1			19
	Medical Causes	16	14	7	17			54
	Vehicle Accident	62	29	19	9			119
	Other Accident	1		1	1			3
	Poisoning	3	2					5
	Suffocation	1						1
	Suicide	14	2	4	1	1		22
	Unknown	1			2			3
	Total	109	48	44	32	1	0	234

APPENDIX C.2 Total Reviewed Child Fatalities

Age	Cause	White Male	White Female	AA Male	AA Female	Other Male	Other Female	Total
Infant (Age<1)								
	Drowning			1				1
	Fire/Burns				1			1
	Homicide	3	3	4	5	1	1	17
	Medical Causes	7	15	16	12	1	3	54
	Vehicle Accident	5	2	3	1		1	12
	Other Accident	1		1				2
	SIDS	13	9	12	8		2	44
	Suffocation	7	4	10	8			29
	SUID	18	11	26	18	2	1	76
	Unknown	1			1			2
	Total	55	44	73	54	4	8	238

Age	Cause	White Male	White Female	AA Male	AA Female	Other Male	Other Female	Total
1 to 4								
	Drowning	8	2	7	1			18
	Fire/Burns	3	1	1	3			8
	Homicide	1	4	8	6	1		20
	Medical Causes	6	3	6	8	1	1	25
	Vehicle Accident	8	4	5	3			20
	Other Accident	1					1	2
	Poisoning	1	1	2				4
	Suffocation	1	2	4	2		1	10
	SUID				1			1
	Unknown	1						1
	Total	30	17	33	24	2	3	109

Age	Cause	White Male	White Female	AA Male	AA Female	Other Male	Other Female	Total
5 to 14								
	Drowning	6	1	2	2			11
	Firearm Accident			1				1
	Fire/Burns	1		9	3			13
	Homicide	3	1	7	6			17
	Medical Causes	4	5	2	12	2		25
	Vehicle Accident	23	19	13	5	1		61
	Other Accident	5		3				8
	Poisoning		1					1
	Suffocation		1					1
	Suicide	2	1	3		1		7
	Unknown Intent	2						2
	Unknown					1		1
	Total	46	29	40	28	5	0	148

Age	Cause	White Male	White Female	AA Male	AA Female	Other Male	Other Female	Total
15 to 17								
	Drowning	3	1			1		5
	Firearm Accident	2		2				4
	Fire/Burns	1			1			2
	Homicide	4	1	10	2			17
	Medical Causes	4		2	3			9
	Vehicle Accident	54	27	17	10	4	1	113
	Other Accident	1		1				2
	Poisoning	4	1					5
	Suicide	14	3	4	1	1		23
	Total	87	33	36	17	6	1	180

APPENDIX C.3 Reviewed Child Fatalities with Abuse Findings

Age	Cause	White Male	White Female	AA Male	AA Female	Other Male	Other Female	Total
Infant (Age<1)								
	Drowning			1				1
	Homicide	3	3	3	5	1	1	16
	Medical Causes	1	2	3	2			8
	Vehicle Accident	2	1	1	1			5
	SIDS		1	2				3
	Suffocation		2	3	4			9
	SUID	2	2	9	6			19
	Unknown				1			1
	Total	8	11	22	19	1	1	62

Age	Cause	White Male	White Female	AA Male	AA Female	Other Male	Other Female	Total
1 to 4								
	Drowning	6	1	5	1			13
	Fire/Burns	2	1					3
	Homicide	1	3	8	6	1		19
	Medical Causes			1				1
	Vehicle Accident	3	1	1				5
	Other Accident						1	1
	Poisoning	1	1	1				3
	Suffocation			3			1	4
	SUID				1			1
	Total	13	7	19	8	1	2	50

Age	Cause	White Male	White Female	AA Male	AA Female	Other Male	Other Female	Total
5 to 14								
	Drowning	3		2				5
	Fire/Burns			2	1			3
	Homicide	1	1	4	5			11
	Medical Causes		1	1	2			4
	Vehicle Accident	3	8	1				12
	Other Accident	1		1				2
	Unknown Intent	2						2
	Unknown					1		1
	Total	10	10	11	8	1		40

Age	Cause	White Male	White Female	AA Male	AA Female	Other Male	Other Female	Total
15 to 17								
	Medical Causes				1			1
	Vehicle Accident	3	2	1				6
	Suicide			2				2
	Total	3	2	3	1			9

APPENDIX C.4

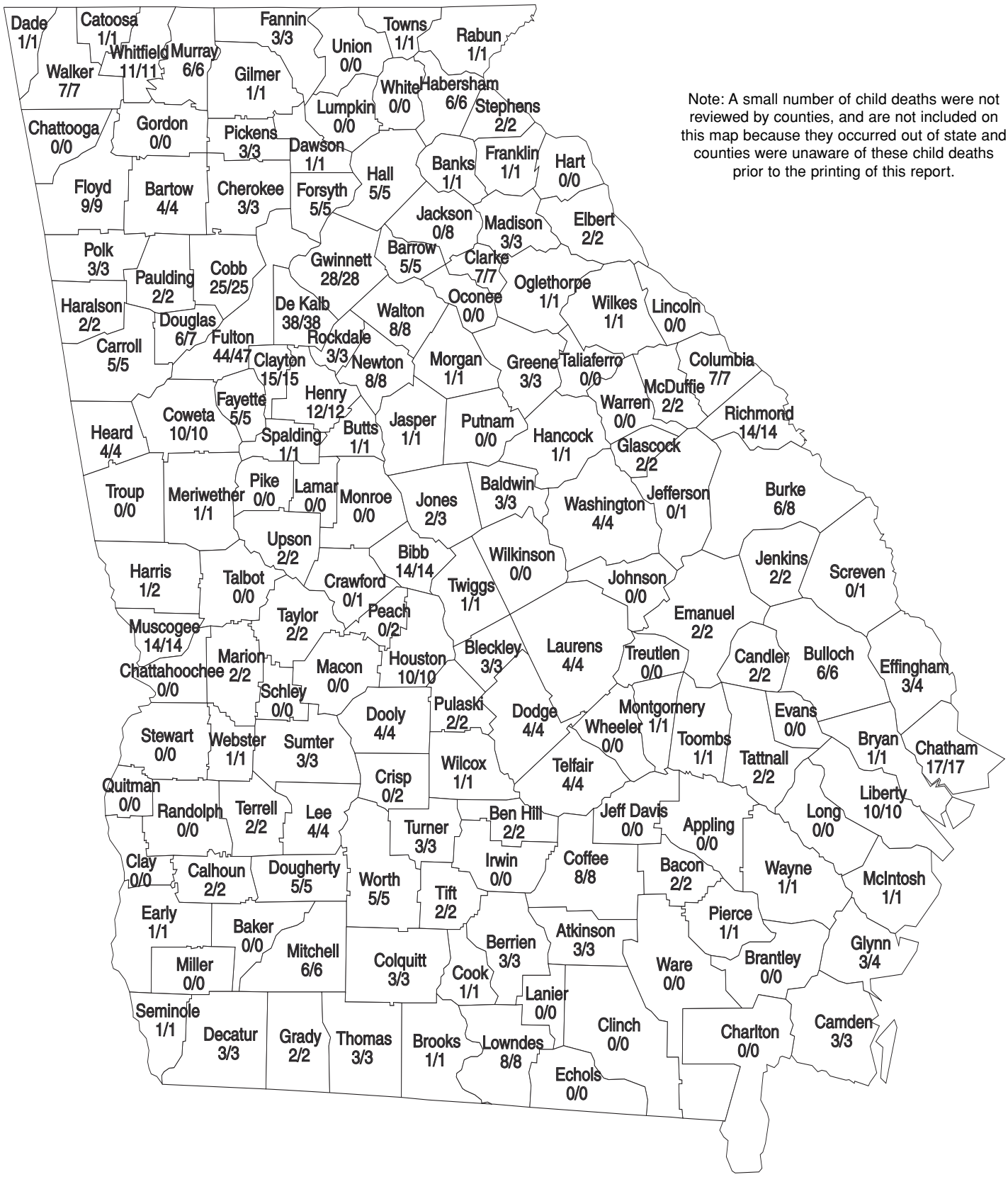
Preventability for Reviewed Deaths with Suspected or Confirmed Abuse or Neglect

Cause	Preventability Not at All	Possibly	Definitely
Drowning			19
Fire/Burns		1	5
Homicide	5	8	33
Medical Causes	1	8	5
Vehicle Accident		3	25
Other Accident		1	2
Poisoning			3
SIDS		3	
Suffocation		3	10
Suicide			2
SUID		17	3
Unknown Intent			2
Unknown		2	
Total	6	46	109

Preventability for Reviewed Deaths with No Suspected or Confirmed Abuse or Neglect

Cause	Preventability Not at All	Possibly	Definitely
Drowning	1	6	9
Firearm Accident		1	4
Fire/Burns	1	13	4
Homicide	5	3	17
Medical Causes	66	31	2
Vehicle Accident	11	79	88
Other Accident	7	3	1
Poisoning		3	4
SIDS	19	22	
Suffocation	3	12	12
Suicide	8	13	7
SUID	13	39	6
Unknown	1		
Total	135	225	154

APPENDIX D
ELIGIBLE DEATHS REVIEWED/ELIGIBLE DEATHS
GEORGIA, 2003



Note: A small number of child deaths were not reviewed by counties, and are not included on this map because they occurred out of state and counties were unaware of these child deaths prior to the printing of this report.

APPENDIX E
2003 CHILD FATALITY REVIEWS, BY COUNTY, BY AGE GROUPS

Appendix E presents county level data for the Child Fatality Review process in 2003. The data is presented for four age groups (infants less than one year old, children from 1 to 4 years of age, children 5 through 14, and teenagers ages 15 through 17). Four numbers are provided for each age group:

All Deaths: The total number of deaths (all causes) for that age group. This number is generally based on Georgia death certificate data and only includes deaths to Georgia residents under the age of 18. This does include deaths of Georgia residents that occurred in other states and were reported back to Georgia, but it does not include deaths of out-of-state residents that occurred in Georgia. The review team of the child's county of residence has the responsibility of reviewing deaths. However, the residence determined by the team may not match the residence reported on the death certificate. The review teams identified four deaths in 2003 that were residents of other states and were coded as Georgia residents on the death certificates. Those four deaths are not included in the child death statistics presented in this report. There were another 15 deaths that had different Georgia counties of residence on the death certificate and the CFR report, and the CFR resident county was used for the data analysis.

Reviewable Deaths: The number of SIDS, unintentional, or violence-related deaths (reviewable deaths) according to the death certificate classifications. Although other deaths due to medical or natural causes may be eligible for review according to OCGA 19-15-3(e), SIDS deaths are explicitly required to be reviewed, and unintentional/violence related deaths should be reviewed as “sudden or unexpected deaths.” Thus, this number represents a minimum number of deaths that should be reviewed. This is a subset of total deaths (DTH).

Reviewable Deaths Reviewed: The number of SIDS, unintentional, or violence related deaths that were reviewed. This number is a measure of how well a county identified and reviewed the minimum number of appropriate deaths. This is a subset of the total “reviewable” deaths. However, there are several sources of error (or inconsistencies) in the county-level tables. The CFR team may have access to additional information regarding the death, and the team may reach a different conclusion regarding the cause of death. For example, a death certificate may be filed with “R99” (undetermined) for the cause of death. The review team may have autopsy or toxicology information that identifies a specific cause. If that is a medical cause, the review team may not complete a review. There were (at least) five deaths in 2003 that met that description, and those five were removed from the list of “reviewable” deaths.

Total Deaths Reviewed: This is the total number of child deaths in 2003 for which a Child Fatality Review Report was submitted. It includes deaths due to natural causes (other than SIDS) in addition to those deaths that were identified as eligible for review. This is based on the county of residence identified from the death certificates.

Appendix E

Child Fatality Reviews, by Death Certificate County of Residence*

County	All Deaths					Reviewable Deaths					Reviewable Deaths Reviewed					Total Deaths Reviewed				
	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total
	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total
Appling	3		1		4													1		1
Atkinson	3		1	2	6			1	2	3			1	2	3			1	2	3
Bacon	1	2	1	1	5			1	1	2			1	1	2			1	1	2
Baker																				
Baldwin	7	2		1	10	1	1		1	3	1	1		1	3	1	1		1	3
Banks			1		1			1		1			1		1			1		1
Barrow	11	1	2		14	2	1	2		5	2	1	2		5	3	1	2		6
Bartow	10	1	4	1	16	1	1	1	1	4	1	1	1	1	4	1	1	1	1	4
Ben Hill	3	1			4	1	1			2	1	1			2	1	1			2
Berrien	3		2	1	6	1		2		3	1		2		3	2		2		4
Bibb	31	5	4	4	44	4	5	2	3	14	4	5	2	3	14	5	5	2	3	15
Bleckley			2	1	3			2	1	3			2	1	3			2	1	3
Brantley	1	1			2															
Brooks	4		1	1	6			1		1			1		1			1		1
Bryan	3		1	1	5				1	1				1	1				1	1
Bulloch	7		2	1	10	3		2	1	6	3		2	1	6	3		2	1	6
Burke	6	3	1	2	12	3	3	1	1	8	1	3	1	1	6	2	3	1	1	7
Butts	3				3	1				1	1				1	1				1
Calhoun			2		2			2		2			2		2			2		2
Camden	5	2			7	1	2			3	1	2			3	1	2	1		4
Candler				2	2				2	2				2	2	1			2	3
Carroll	11		1	4	16	1		1	3	5	1		1	3	5	5		1	3	9
Catoosa	6		1		7			1		1			1		1			1		1
Charlton	1		2		3													1		1
Chatham	42	2	9	4	57	7	2	5	3	17	7	2	5	3	17	8	3	6	3	20
Chattahoochee	2				2															
Chattooga	5				5											5				5
Cherokee	15	2	3	1	21	1	1	1		3	1	1	1		3	2	1	3		6
Clarke	17	2	1	2	22	4	1	1	1	7	4	1	1	1	7	5	2	1	1	9
Clay		1			1															
Clayton	42	6	8	6	62	4	3	2	6	15	4	3	2	6	15	10	6	3	6	25
Clinch	1				1															
Cobb	51	11	17	7	86	6	3	11	5	25	6	3	11	5	25	7	7	13	6	33
Coffee	9	1	6	1	17	1	1	5	1	8	1	1	5	1	8	1	1	5	1	8
Colquitt	4		3	1	8	1		1	1	3	1		1	1	3	1		1	1	3
Columbia	5		2	9	16			1	6	7			1	6	7			1	6	7

Appendix E

Child Fatality Reviews, by Death Certificate County of Residence*

County	All Deaths					Reviewable Deaths					Reviewable Deaths Reviewed					Total Deaths Reviewed				
	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total
Cook	2	1	1		4		1			1		1			1		1			1
Coweta	14	2	2	6	24	3	1		6	10	3	1		6	10	3	1		6	10
Crawford	1				1	1				1										
Crisp	4	1	1	1	7		1	1		2									1	1
Dade	1				1	1				1	1				1	1				1
Dawson	2				2	1				1	1				1	1				1
Decatur	5	1	2	3	11		1		2	3		1		2	3		1		2	3
DeKalb	97	12	17	16	142	12	7	7	12	38	12	7	7	12	38	16	10	10	13	49
Dodge	2		2	3	7			1	3	4			1	3	4			1	3	4
Dooly	2	2		1	5	1	2		1	4	1	2		1	4	2	2		1	5
Dougherty	14	4	1	1	20	2	3			5	2	3			5	2	3			5
Douglas	13	2	6	2	23	3	2	1	1	7	2	2	1	1	6	2	2	1	1	6
Early	4			1	5				1	1				1	1				1	1
Echols																				
Effingham	6	1	1	4	12	2			2	4	1			2	3	1			2	3
Elbert	5		1	1	7			1	1	2			1	1	2			1	1	2
Emanuel	7		2	1	10	1		1		2	1		1		2	1		1		2
Evans	1				1															
Fannin	2		1	2	5	1			2	3	1			2	3	1			2	3
Fayette	4		2	5	11	1		1	3	5	1		1	3	5	1		1	3	5
Floyd	16	4	2		22	6	1	2		9	6	1	2		9	7	3	2		12
Forsyth	10	1	2	4	17	1		1	3	5	1		1	3	5	1		1	3	5
Franklin	1		1		2			1		1			1		1			1		1
Fulton	105	19	21	17	162	18	8	11	11	48	17	7	11	9	44	21	11	16	11	59
Gilmer			1		1			1		1			1		1			1		1
Glascock	1			1	2	1			1	2	1			1	2	1			1	2
Glynn	7	1	1		9	3		1		4	3				3	4				4
Gordon	8				8															
Grady	7	1	4		12	1		1		2	1		1		2	3	1	3		7
Greene	6		1		7	2		1		3	2		1		3	2		1		3
Gwinnett	79	10	18	13	120	4	3	11	11	29	4	3	11	10	28	5	3	11	11	30
Habersham	1	5	1	1	8		5		1	6		5		1	6		5		1	6
Hall	16	1	6	3	26			4	1	5			4	1	5			4	1	5
Hancock	2			1	3				1	1				1	1				1	1
Haralson	2	1			3	1	1			2	1	1			2	3	1			4
Harris	2	1	1	1	5		1		1	2				1	1			1	1	2

Appendix E

Child Fatality Reviews, by Death Certificate County of Residence*

County	All Deaths					Reviewable Deaths					Reviewable Deaths Reviewed					Total Deaths Reviewed				
	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total
Hart																				
Heard	1		1	3	5			1	3	4			1	3	4			1	3	4
Henry	22		3	8	33	5		2	5	12	5		2	5	12	7		2	7	16
Houston	20	5	1	1	27	5	4	1		10	5	4	1		10	7	4	1		12
Irwin			1		1															
Jackson	10	1	3	2	16	4	1	1	2	8										
Jasper	1				1	1				1	1				1	1				1
Jeff Davis	1			1	2															
Jefferson	3	1	1	1	6				1	1										
Jenkins	1		1	1	3	1			1	2	1			1	2	1			1	2
Johnson		1			1												1			1
Jones	5	1		1	7	2			1	3	1			1	2	1			1	2
Lamar	2				2															
Lanier	3				3															
Laurens	6	1	2	4	13	1		1	2	4	1		1	2	4	1		1	2	4
Lee	4		3	1	8			3	1	4			3	1	4			3	1	4
Liberty	10	1	4	3	18	5		2	3	10	5		2	3	10	5	1	3	3	12
Lincoln	1				1															
Long																				
Lowndes	24	1	1	7	33	1	1		6	8	1	1		6	8	4	1		6	11
Lumpkin	1	1			2															
Macon	2				2															
Madison	3	1	1	1	6	2		1	1	4	2		1		3	2	1	1		4
Marion	1	1		1	3		1		1	2		1		1	2		1		1	2
McDuffie	5		2	1	8			1	1	2			1	1	2			1	1	2
McIntosh	1			1	2				1	1				1	1				1	1
Meriwether	2		1		3	1				1	1				1	1				1
Miller	1				1															
Mitchell	5	1	1	2	9	2	1	1	2	6	2	1	1	2	6	2	1	1	2	6
Monroe	3				3															
Montgomery	2				2	1				1	1				1	1				1
Morgan			2		2			1		1			1		1			1		1
Murray	4	1	3	4	12		1	1	4	6		1	1	4	6		1	1	4	6
Muscogee	43	7	5	5	60	7	3	1	3	14	7	3	1	3	14	8	5	2	3	18
Newton	12	1	2	2	17	4	1	1	2	8	4	1	1	2	8	5	1	1	2	9
Oconee	2				2															
Oglethorpe	2		1		3			1		1			1		1			1		1
Paulding	6		1	3	10				2	2				2	2				2	2

Appendix E

Child Fatality Reviews, by Death Certificate County of Residence*

County	All Deaths					Reviewable Deaths					Reviewable Deaths Reviewed					Total Deaths Reviewed				
	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total
Peach	1	3			4	1	1			2										
Pickens	6				6	3				3	3				3	3				3
Pierce	1			1	2				1	1				1	1				1	1
Pike																				
Polk	4		1	2	7			1	2	3			1	2	3			1	2	3
Pulaski			2	1	3			1	1	2			1	1	2			1	1	2
Putnam	3				3															
Quitman																				
Rabun			1		1			1		1			1		1			1		1
Randolph	4				4															
Richmond	39	3	7	5	54	8	1	2	3	14	8	1	2	3	14	10	1	2	3	16
Rockdale	6	1		4	11				3	3				3	3	1			3	4
Schley																				
Screven	5		1		6	1				1										
Seminole	2				2	1				1	1				1	1				1
Spalding	13	2			15	1				1	1				1	1	1			2
Stephens	2	1	1	2	6				2	2				2	2	1			2	3
Stewart	3				3															
Sumter	5		1		6	3				3	3				3	3				3
Talbot																				
Taliaferro																				
Tattnall	3	1		1	5		1		1	2		1		1	2		1		1	2
Taylor			1	2	3				2	2				2	2				2	2
Telfair	2		2	1	5	2		2		4	2		2		4	2		2		4
Terrell	5				5	2				2	2				2	2				2
Thomas	5		1	1	7	1		1	1	3	1		1	1	3	1		1	1	3
Tift	1		4	1	6			1	1	2			1	1	2			1	1	2
Toombs		1		1	2				1	1				1	1		1		1	2
Towns	1		1	1	3				1	1				1	1				1	1
Treutlen	1				1															
Troup	7	1		1	9											1	1			2
Turner	2			1	3	2			1	3	2			1	3	2			1	3
Twiggs	3			1	4				1	1				1	1				1	1
Union	1		1		2													1		1
Upson	2				2	2				2	2				2	2				2
Walker	10		4	1	15	3		4	1	8	3		3	1	7	3		3	1	7

Appendix E

Child Fatality Reviews, by Death Certificate County of Residence*

County	All Deaths					Reviewable Deaths					Reviewable Deaths Reviewed					Total Deaths Reviewed				
	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total	<1	1-4	5-14	15-17	Total
Walton	9	3		4	16	2	2		4	8	2	2		4	8	3	3		4	10
Ware	1				1											1				1
Warren	1				1															
Washington	6			1	7	3			1	4	3			1	4	3			1	4
Wayne	3			2	5				2	2				1	1				1	1
Webster	1			1	2				1	1				1	1				1	1
Wheeler			1		1													1		1
White	1		1		2															
Whitfield	12	2	1	5	20	5	2		4	11	5	2		4	11	6	3		4	13
Wilcox	1	1	1		3			1		1			1		1		1	1		2
Wilkes	3				3	1				1	1				1	1				1
Wilkinson	2	1			3															
Worth	3	2	2		7	2	2	1		5	2	2	1		5	2	2	1		5
Totals	1,150	160	250	234	1,794	194	84	128	180	586	181	79	124	172	556	238	109	148	180	675

* See page 51 - All Deaths

APPENDIX F
DEFINITIONS OF TERMS AND ABBREVIATIONS USED IN THIS REPORT

AA
African American

Child Abuse Protocol Committee
County level representatives from the office of the sheriff, county department of family and children services, office of the district attorney, juvenile court, magistrate court, county board of education, office of the chief of police, office of the chief of police of the largest municipality in county, and office of the coroner or medical examiner. The committee is charged with developing local protocols to investigate and prosecute alleged cases of child abuse.

Child Fatality Review Report
A standardized form required for collecting data on child fatalities meeting the criteria for review by child fatality review committees.

Child Fatality Review Committee
County level representatives from the office of the coroner or medical examiner, county department of family and children services, public health department, juvenile court, office of the district attorney, law enforcement, and mental health.

Eligible Death
Death meeting the criteria for review including death resulting from SIDS, unintentional injuries, intentional injuries, medical conditions when unattended by a physician, or any manner that is suspicious or unusual.

Form 1
A standardized form required for collecting data on all child fatalities by corners or medical examiners.

Georgia Child Fatality Review Panel
An appointed body of 17 representatives that oversees the county child fatality review process, reports to the governor annually on the incidence of child deaths, and recommends prevention measures based on the data.

Injury
Refers to any force whether it be physical, chemical (poisoning), thermal (fire), or electrical that resulted in death.

Intentional
Refers to the act that resulted in death being one that was deliberate, willful, or planned.

Medical Cause
Refers to death resulting from a natural cause other than SIDS.

Natural Cause
Refers to death resulting from an inherent, existing condition. Natural causes include congenital anomalies, diseases of the nervous system, diseases of the respiratory system, other medical causes and SIDS.

"Other" Race
Refers to those of Asian, Pacific Islander, or Native American origin.

"Other" as Category of Death
Includes deaths from poisoning and falls (unless otherwise indicated).

Perpetrator
Person(s) who committed an act that resulted in the death of a child.

Preventable Death
One in which with retrospective analysis it is determined that a reasonable intervention could have prevented the death. Interventions include medical, educational, social, legal, technological, or psychological.

Reviewed Death
Death which has been reviewed by a local child fatality review committee and a completed Child Fatality Review Report has been submitted to the Georgia Child Fatality Review Panel.

Risk Factor
Refers to persons, things, events, etc. that put an individual at an increased likelihood of dying.

Sudden Infant Death Syndrome (SIDS)
Sudden death of an infant under one year of age which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene and review of the clinical history. In this report, SIDS is not considered a "medical" cause.

Sudden Unexplained Infant Death (SUID) is a category used by child fatality review committees for deaths that appear to be SIDS but have other risk factors that could have contributed to the infant's death.

Trend
Refers to changes occurring in the number and distribution of child deaths. In this report, the actual number of deaths for each cause is relatively small for the purpose of statistical analysis, which causes some uncertainty in estimating the risk of death. Therefore, caution is advised in making conclusions based on these year-to-year changes which may only reflect statistical fluctuations.

Unintentional Death
Refers to the act that resulted in death being one that was not deliberate, willful, or planned.

NOTES